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health system
reform

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JANUARY 14 1994



Illinois Civil
Justice League
battles for
change

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Ron Ackerman

Rep. Michel

U.S. HOUSE MINORITY LEADER ROBERT MICHEL (R-Peoria) receives feedback about health system reform during a Dec. 4 town hall meeting in Springfield co-sponsored by Michel and U.S. Reps. J. Dennis Hastert (R-Batavia) and Thomas Ewing (R-Bloomington).

Government releases RBRVS rule, proposed safe harbors

MEDICARE: New regulations will affect physicians' reimbursement and payment practices.

[WASHINGTON] In late 1993, the federal government issued regulatory information for physicians regarding the Medicare and Medicaid anti-kickback laws and the 1994 Medicare fee schedule.

The rates included in this year's RBRVS Medicare fee schedule will increase payments to most physicians, although some doctors will experience decreases, according to an ISMS analysis of the fee schedule. The U.S. Health Care Financing Administration raised one of the conversion factors for 1994 by as much as 10 percent, but the agency also imposed a 1.3-percent cut in relative value units to ensure that overall Medicare expenditures remain budget

neutral. Some rates were cut further due to scheduled decreases required by the ongoing phase-in of RBRVS, the ISMS analysis stated.

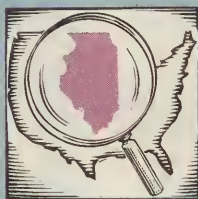
Physicians will see other changes in the fee schedule conversion factors. For the first time, HCFA separated primary care services from nonsurgical services, resulting in three conversion factors for 1994. Last year, physicians used only two conversion factors to compute their Medicare reimbursements. According to the fee schedule, the 1994 surgical services conversion factor rose 10 percent to \$35.16; the primary care services conversion factor increased 7.9 percent to

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New law changes tax status of dues

Effective Jan. 1, federal law prohibits individuals from deducting the portion of their professional society dues that is spent on lobbying. Prior to the law, 100 percent of medical society dues were considered tax deductible as an ordinary and necessary business expense.

ISMS is currently informing members by mail about what percentage of their 1994 dues will be deductible. According to Internal Revenue Service guidelines, the law will also apply to 1994 dues that were prepaid in 1993. ISMS recommends that physicians consult their personal tax advisers regarding their individual circumstances.

For more information, physicians may call the Society at (312) 782-1654 or (800) 782-ISMS, ext. 1122.

Medicine, government address antitrust issues

COMPETITION: The federal government is using antitrust laws to crack down on health care ventures. By Gina Kimmey

[CHICAGO] In November 1993, the federal government used antitrust laws for the first time to require changes in a joint venture between physicians and medical supply companies in two counties in California, according to federal officials speaking on antitrust reform Dec. 9 during the Illinois State Bar Association's midyear meeting in Chicago.

The so-called home oxygen cases involved partnerships that created companies to provide oxygen delivery systems to patients in their homes, said Mark Whitener, acting deputy director of the FTC Bureau of Competition. The oxygen systems were prescribed by pulmo-

nologists who had financial interests in the companies, he said. The FTC complaints alleged that 60 percent of the practicing pulmonologists in each area were investors in those companies and that their collective market power and incentive to refer patients "created barriers to entry and restrained competition in the market for home oxygen systems," Whitener added.

Under a settlement arrangement with the FTC, the companies agreed to reduce physician investments in the partnerships to no more than 25 percent of the investments of practicing pulmonologists in each area.

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Legislators discuss rural physician shortage

PRIMARY CARE: Groups suggest ways to increase the number of doctors Downstate. By Gina Kimmey

[HARRISBURG] Many pregnant women living in Illinois' seven southernmost counties hope they go into labor between 6 a.m. and 6 p.m., according to Sharon Mumford, a Southern Seven Health Department official. That 12-hour window is the only time some women can catch the ferry to Salem, Ky., where the nearest hospital offering obstetric services is located, Mumford said at a Dec. 13 public hearing in Harrisburg.

The forum was convened by the General Assembly's Special Joint Task Force on Family Physician Shortages. Individuals

who testified outlined the problems faced by communities without physicians and discussed such solutions as tort reform, financial incentives and improved primary care training.

Lawmakers created the bipartisan task force last summer and charged it with studying the cause and impact of family physician shortages in Illinois. In addition to members of both houses of the legislature, the task force includes representatives from ISMS, the Illinois Department of Public Health, the Illinois Academy of Family Physicians, the Illinois Hospital Association.

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Illinois tax forms include cancer research checkoffs

DONATIONS: Taxpayers can help fight breast and cervical cancer.
By Gina Kimmey

[SPRINGFIELD] Illinois taxpayers can contribute to breast and cervical cancer research through a new charity checkoff on 1993 state income tax returns. Two other health-related funds – Alzheimer's disease and AIDS research – were already listed on tax forms, according to the Illinois Department of Public Health.

Illinois Sen. Chris Lauzen (R-Geneva) said he sponsored the bill that placed the cancer funds on tax forms, because breast cancer affects so many people. "This is such a huge problem. One out of eight women by the age of 85 will have some problems with breast cancer. These women are our wives, mothers, daughters, sisters and friends."

Donations for breast and cervical cancer research from 1993 returns will be

directed to IDPH, and an advisory committee will determine how the money is distributed, Lauzen explained. Representatives from the American Cancer Society and Y-Me – an Illinois-based national organization that provides support to breast cancer patients – will serve on the advisory committee, he said. "So, instead of government people deciding who gets what, there are people involved with breast cancer work helping to make those decisions."

Individual funds must receive at least \$100,000 in donations to remain on tax forms from year to year, Lauzen noted. "What's most important right now is that people know the need is there and that we need \$100,000 just to stay in the ball game." ■

IDPH receives smoking cessation grant

[SPRINGFIELD] The Illinois Department of Public Health received a \$237,000 grant to increase public awareness about the dangers of smoking and implement cessation programs, the department announced last fall. In addition to Illinois, 21 states received grants from the U.S. Centers for Disease Control and Prevention. The grants will help states create or reinforce cessation programs and dissuade teens from starting to smoke.

"Our goal is to reduce the number of people in the state who smoke and to ultimately reduce the number of smoking-related illnesses and deaths," said IDPH Director John R. Lumpkin, MD.

The grant will fund five pilot programs throughout the state to "change social norms and views on smoking, and get the word out that it is an ugly, dangerous habit," said Karen Greuter, an IDPH spokesperson. Local health, social service and other state departments will help develop the programs. Participating organizations include the American Lung Association, the American Cancer Society, the Illinois Coalition Against Tobacco, the March of Dimes and the Illinois Department of Alcoholism and Substance Abuse, according to Greuter.

In addition, the department plans to prompt the introduction of legislation to limit access to tobacco, create a more stringent anti-smoking campaign and initiate a strong media campaign, Greuter said.

"In 1991, more than 20,000 people died of smoking-related deaths in Illinois," Dr. Lumpkin said. "That same year, costs for smoking-related illnesses for people 35 years of age and older totaled \$3.5 billion. These are issues that cannot be ignored."

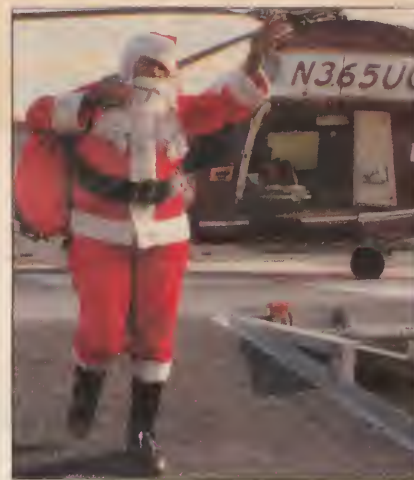
The new programs will target groups among whom smoking is most prevalent, including youth, minorities, blue-collar workers, individuals who did not complete high school, and women who are pregnant or of childbearing age, Greuter noted. "Where we can make people aware of the dangers of smoking, we can reduce smoking."

A drop in the number of people who smoke would also decrease the number of people exposed to secondhand smoke, Dr. Lumpkin added.

According to the American Cancer Society, 25 percent of all smokers will die from diseases caused by smoking. In 1991, 20,133 deaths were attributed to smoking. Of those, 19,893 people died of lung cancer or other cancers, heart disease, respiratory ailments or other illnesses directly related to smoking; 240 people died from smoking-related fires and accidents.

The department expects the CDC to make additional funds available annually over the next four years. ■

SANTA CLAUS traded in his traditional reindeer and sleigh for the University of Chicago Hospitals' Aeromedical Network helicopter to deliver presents to patients at Wyler Children's Hospital on Dec. 23. Ambulatory patients went to an enclosed glass room on the roof to watch Santa arrive and then escorted him to the hospital's playroom for a party. The annual event is co-sponsored by the hospital and the helicopter team.



Wm. Daniels/The Photo Partners

Teen AIDS conference tackles diverse issues

[CHICAGO] Using the theme "Taking It to the Streets," physician speakers at the fifth annual Adolescent AIDS Conference at Rush-Presbyterian-St.

Luke's Medical Center in Chicago focused on a variety of issues affecting HIV-infected adolescents. Attendees of the Nov. 12 conference included representatives from hospitals, medical schools and nonprofit organizations that work with young AIDS patients. Sponsored by the Chicago Department of Health, Rush Medical College and the Consortium on Youth and AIDS, the

conference highlighted the importance of recognizing the complexity of adolescent health problems.

"As adolescents' health care needs become increasingly complex, their access to medical care has been greatly diminished," said keynote speaker Richard MacKenzie, MD, director of the adolescent medicine program at the Children's Hospital of Los Angeles. "They are often uninsured and naive about health care systems, don't know their confidentiality rights and may be frightened, especially if they live in a small community."

To treat adolescents, health care providers must recognize that teens are fundamentally different from adults, Dr. MacKenzie said. "We have to be advocates for our disenfranchised youth. We have all been adolescents at one time, but we are not the gold standard of a normal adolescence." He stressed that physicians and other providers should drop the paradigm that their own experiences as teens were normal and all others are abnormal. Instead, they must look at adolescents in light of "today's environment and today's toxicities," he said.

Virginia Bishop-Townsend, MD, director of adolescent medicine at the University of Illinois College of Medicine, described a study in which Washington, D.C., teens were interviewed at an urban adolescent health clinic and an HIV clinic. The study revealed that the HIV-positive adolescents were at much greater risk for violence, alcohol and drug use and other high-risk behaviors.

"It seems as though some of these kids have a death wish," Dr. Bishop said of the HIV-positive patients. "They kept repeatedly putting themselves in dangerous situations, almost as if they wanted somebody else to end their lives, since they had already been issued a death warrant."

"When working with youth, if you can empathize with their dilemma, you can be much more creative in your ability to make [them] change," Dr. MacKenzie said. ■

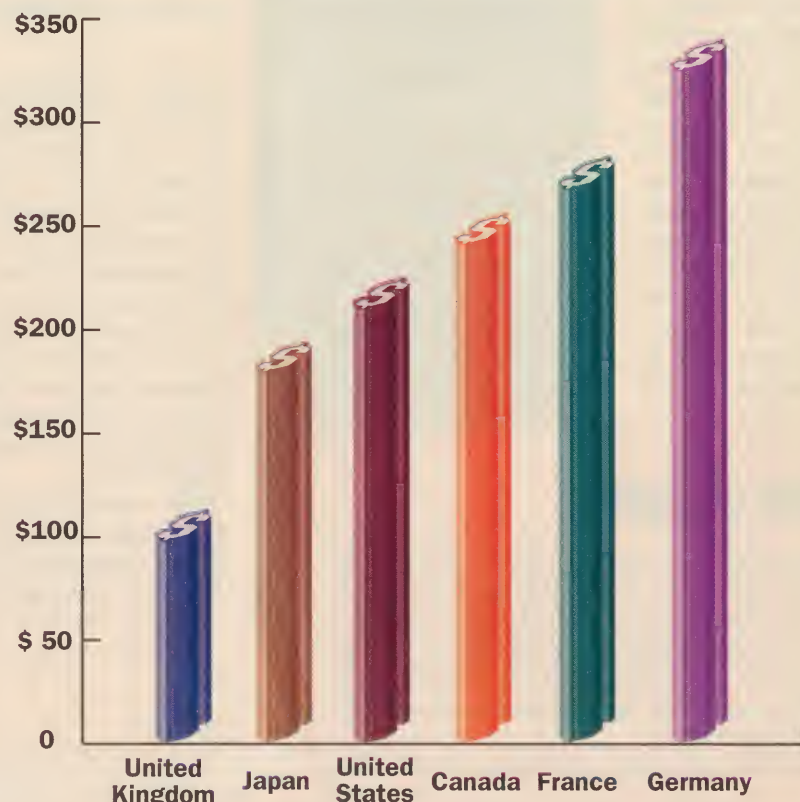


Dr. MacKenzie

Brian Waring

PHYSICIAN FACTS

Pharmaceutical costs around the world Annual per-person spending on prescription drugs



Source: Pharmaceutical Manufacturers Association

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Infant mortality rate reaches historic low

[SPRINGFIELD] Gov. Jim Edgar announced last fall that Illinois' infant mortality rate reached its lowest level ever in 1992 at 10 deaths per 1,000 live births. That number is 6.5 percent lower than the previous all-time lows reached in 1990 and 1991, when the state's infant mortality rate was 10.7 deaths per 1,000 births, according to Illinois Department of Public Health statistics. The national infant mortality rate was 9.2 in 1990, according to the U.S. Centers for Disease Control and Prevention.

Chicago's infant mortality rate – the highest in the state at 15.1 in 1991 – decreased to 13.3 in 1992. Downstate Illinois experienced a slight decrease from 8.6 in 1991 to 8.5 in 1992, IDPH said.

"We are pleased to be making progress, but are committed to making even more gains through outreach initiatives, such as our Healthy Moms/Healthy Kids program," Edgar said. "We are still seeing too many babies born too soon or too small or into conditions of extreme poverty. So we are educating mothers-to-be about early and comprehensive prenatal care, proper nutrition and family planning."

Proposed in 1992, the Healthy Moms/Healthy Kids program began in April 1993 as an expansion of the Families with a Future program, which had previously served only needy families in areas with high infant mortality rates. The program was created to ensure that pregnant women and children under 6 on Medicaid receive routine health care services, according to the governor.

"Too many babies are dying needlessly before the age of 1, particularly African-American infants," said IDPH Director John R. Lumpkin, MD. "This administration is dedicated to programs that will drive down the infant mortality rate and ultimately save taxpayer dollars by preventing major medical problems for children who rely on government assistance." ■

Governor's reform task force continues work

[CHICAGO] Preliminary ideas for reforming Illinois' health care system were presented during a November meeting of Gov. Jim Edgar's Health Care Reform Task Force. Since last meeting as a group on Feb. 1, 1993, the task force was divided into five working groups addressing access, finance, long-term care, managed care and medical malpractice. Those groups spent most of 1993 developing research reports on selected reform topics, which they shared with the full task force Nov. 19. The task force is scheduled to deliver its recommendations to Edgar in March, according to John Washburn, task force vice chairman.

"We are now looking at how we need to restructure or reposition our plan to ensure that we get it done in a way that makes sense with what's happening in Washington," Washburn said. "Of course, the national reforms will have a big impact on what we do here in Illinois. [Washington] will set up the framework for what each state can do. We must have a good feeling for what is happening nationally." ■

ASIM offers managed care workshop

[WASHINGTON] Physicians can learn how to adapt their medical practices to the economic realities of managed care at an American Society of Internal Medicine seminar Feb. 10 in Chicago. "Preparing Your Practice for the New Economic Environment: Focus on Managed Care" is designed to help physicians position themselves in the increasingly competitive health care marketplace, said Alan R. Nelson, MD, ASIM executive vice president.

"Regardless of which health reform

package 'wins,' the handwriting is on the wall," Dr. Nelson said. "The quantity and type of managed care arrangements, which have been moving into the market for years, will explode over the next few years in both the private and public sectors. Physicians in internal medicine and its subspecialties need to equip themselves to make the most of these changes."

Among the topics to be covered are comparing and choosing managed care plans, sharpening contract negotiation skills and maximizing collections. The program will also explain how to use managed care payment policies and reorganize office activities to accommodate managed care patients more effectively.

In addition, program presenters will discuss key points to include and avoid in managed care contracts.

The workshop is intended for internists, subspecialists, and office managers and staff responsible for the business and administrative aspects of medical practice. Registration is \$195 for ASIM members and \$225 for nonmembers. Additional participants from the same practice are eligible for a discount. For more information, contact Susan Kern at (202) 835-ASIM, ext. 266.

ASIM has applied for six hours of category 1 CME credit for the AMA Physician's Recognition Award. ■



REPORT FOR *Illinois Physicians*

MEDICARE EXPANDS PROVIDER EDUCATION FOR 1994

Medicare Part B gave more than 120 specialty and basic presentations on claims submission to the Illinois provider community during 1993. Among those specialty areas addressed were Internal Medicine, Family Practice/General Practice, Chiropractic, Podiatry, Ambulance Service, Surgery, Cardiology, Radiology and Anesthesiology. In addition, numerous presentations of the half-day "Medicare Basics", geared for those newer to Medicare B billing, were offered. Comments from those attending these presentations were very positive.

For 1994, the Medicare Part B Provider Education Team hopes to expand its role in addressing the needs of the provider community by drawing attention to the importance of having working knowledge in all areas of claims submission. Presentations will emphasize that the ultimate responsibility of claims accuracy rests on the part of the provider of services. A wide array of specialty claims submission seminars will be offered. In addition, a new product, the Medicare B **Learning Lab** will be offered in various locations throughout Illinois.

Like the "Medicare Basics" seminar, the **Learning Lab** is for those newer to Medicare billing, yet is offered as an all-day program. The **Learning Lab** an interactive, hands-on approach to learning proper claims submission. The sessions are presented in a classroom format, and use examples, simulated claims exercises, handouts, and self-tests to aid in mastering the topics presented. The number of attendees at each **Learning Lab** is limited to allow for maximum participation.

Seminars are offered to those needing specific information about a particular specialty. Presented in lecture format, seminars include question and answer interaction from the audience, yet are less remedial in their approach than the Learning Labs.

Please watch for listings and reservation forms for these presentations in upcoming issues of the Medicare B **Bulletin**. Should you have additional requests or suggestions for the Provider Education Team, please address them to:

J. David Bozarth, Coordinator
Medicare B Provider Education
Blue Cross Blue Shield of Illinois
P. O. Box 210
Chicago, IL 60690

Hearing airs reform concerns

STRATEGY: Illinois legislators begin formulating the state's position on health system reform. By Anna Chapman

[SPRINGFIELD] During the first of several slated hearings about Illinois' role in health system reform, representatives from various groups, including ISMS, voiced concerns about the president's reform legislation. Those testifying during the Dec. 7 hearing in Springfield also listed their priorities for enacting reforms at the state level.

The hearings are being conducted by

the Illinois Response to National Health Reform Subcommittee, composed of members of the Illinois House of Representatives' Health Care and Human Services Committee. The subcommittee will use the information gathered at the hearings to develop a General Assembly action plan to influence national reform, said Rep. David Phelps (D-Eldorado), chairman of the health committee and

the subcommittee. Phelps said he hopes the subcommittee will be ready to recommend a strategy to the General Assembly by the end of the 1994 spring session.

"The subcommittee does not intend to write a national health care plan," Phelps said. "We will be attempting to identify major issues relating to our state so that we can advise the U.S. Congress in its work. In the first place, we will try to decide if there are major points of support or opposition that should be sent to appropriate leaders and committees in the U.S. House of Representatives and the Senate."

In addition to ISMS, others testifying included U.S. Rep. Richard J. Durbin (D-

Springfield) and representatives from the General Assembly's Washington office and the Illinois Hospital Association.

ISMS TESTIMONY CENTERED on the Society's fiscal analysis of the president's reform legislation, H.R. 3600 and S. 1757. According to the testimony, the president's bills lack adequate funding mechanisms, which could limit access. In the short term, low expenditure limits could restrict access to expensive treatments and services, and decreased funding could curtail costly medical advancements. In the long term, inadequate financing could cause outright rationing, which would become more severe over time, according to the ISMS testimony.

The Clinton plan relies on complex formulas to calculate reimbursement amounts and limits, making it nearly impossible to estimate their impact on the system, ISMS said. The plan also proposes savings by restricting physicians' fees. This could also cause access problems, as providers might deliver fewer services given the lower fees.

Overall, ISMS said that the Clinton plan would probably harm the current system and likely would not achieve universal access to a comprehensive benefits package.

IN HIS TESTIMONY, Durbin said the nation's health care system is "in desperate need of reform" but noted that legislators must attempt to protect its advantages. "Without reform, costs will continue to mount. Clinton focused extensively on the role of the states. It's your responsibility to craft Illinois' health care plan. It's up to us to decide what's best."

Durbin and other testifiers emphasized the need for Illinois to develop its own reform plan. He said seven states have already formulated such plans. An early strategy would "put Illinois ahead of other states, rather than taking a wait-and-see attitude," he added.

Tom Faletti, Durbin's legislative director and a member of Hillary Rodham Clinton's reform task force, told the subcommittee that if the Clinton plan is approved, each state will have until 1998 to implement a plan that meets federal guidelines. States will have flexibility but will need to ensure access and determine the number and structure of the health alliances formed.

THE CLINTON PROPOSAL "shows lack of faith in the market," said Allison Laabs, executive vice president and chief executive officer of St. John's Hospital in Springfield, testifying on behalf of IHA. He said hospitals are concerned that the president's plan would not allow enough time to develop provider networks properly. "It's better to go slowly with access expansion," he noted. Hospitals are also concerned that health alliances would be "too big and too complex and would have to work from day one" under the Clinton plan. Laabs said alliances would have near monopoly power and would not necessarily be permitted to cross state lines.

"From the beginning, state legislators made it clear to the [Clinton] administration and to members of Congress who were developing their own plans that health care reform must promise access, if not coverage, for everyone," said Van Esser, director of the Illinois General Assembly's Washington office. "After it was over, we felt that we had been given an opportunity to speak our minds." ■

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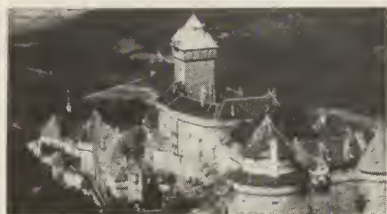
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Federal legislators focus on shaping health system reform

REACTION: As debate continues in the Capitol, lawmakers urge physicians to participate.

By Anna Chapman

[WASHINGTON] Following the introduction of several pieces of legislation, including the president's Health Security Act, several U.S. representatives from Illinois agree that access to care and cost control are key reform issues. U.S. Reps. Richard J. Durbin (D-Springfield), John Porter (R-Deerfield) and J. Dennis Hastert (R-Batavia) said they want reform to provide health care for everyone. All three indicated they hope to play important roles in shaping health system reform. They have participated in reform-related events throughout the country, including AMA forums, editorial board discussions and town meetings.

One of Durbin's goals for reform is ensuring that pre-existing conditions do not exclude anyone from receiving health insurance coverage. Durbin said he has been able to provide input into the national reform debate because his legislative director sat on the Clintons' health care reform task force.

While attending town hall meetings last year, Porter said he heard poignant stories about individuals who lost their health insurance coverage after being diagnosed with terminal diseases. "Any reform is definitely going to have to include access to care for those with negative health histories. This is essential."

Durbin said he has a "rural view" of expanding access. To ensure access in rural areas, small hospitals must stay open, he said. Although several recent reports have theorized that the United States has too many physicians, Durbin said he believes focusing on the total number of doctors is misleading. He noted that many rural communities are experiencing physician shortages, while his hometown of Springfield has "hundreds of physicians. I don't think doctors are distributed well."

Durbin is also not convinced that the health care system is overloaded with specialists. He said he has received a significant amount of feedback from specialists who are concerned about the president's emphasis on primary care. "We need to use physicians in the most efficient, cost-effective manner."

Porter said he opposes the Clinton plan because it calls for additional government intrusion and bureaucracy. "We must preserve the wonderful system we have today."

Porter said he opposes the Clinton plan because it calls for additional government intrusion and bureaucracy. "We must preserve the wonderful system we have today."

MEDICAL LIABILITY REFORM is another overriding reform issue, Porter said. In the mid-1980s, he formed a medical malpractice reform group that prompted a study by the U.S. General Accounting Office. The results were used to justify enactment of liability reform laws in several states, he said.

"Tough malpractice reform is central to cost containment," Hastert added. "Defensive medicine and the cost of insurance drive health care costs tremendously." Hastert, who served as the Republican representative on the White House task force, advocates national tort reforms such as caps on noneconomic damages in malpractice suits, caps on attorneys' fees and changes in product liability laws. He also supports English law, whereby the losers in liability cases pay court and attorneys' fees.

Hastert also emphasized the need for antitrust reform, noting that it would enable physicians and hospitals to share information and technologies. Antitrust reform would be a "great piece of cost containment," he said.

Other issues on Hastert's reform agenda include simplified insurance forms, electronic billing and medical IRAs. Medical savings accounts would encourage patients to test the medical market-

place when seeking care. "It gives patients the incentive to get good care at the best cost," he explained.

Hastert stressed that the current health system is not badly broken. "I believe we have the best health care in the world."

"This is going to be a long and very large national debate," Porter added. "It's going to be about how much government we want. It's also a very good opportunity for input. Every physician should not only be talking to his or her congressman, but be building a base of support among patients. That's what is really going to influence reform." ■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

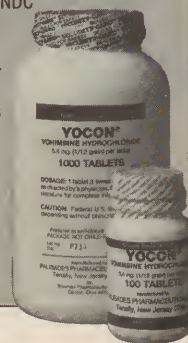
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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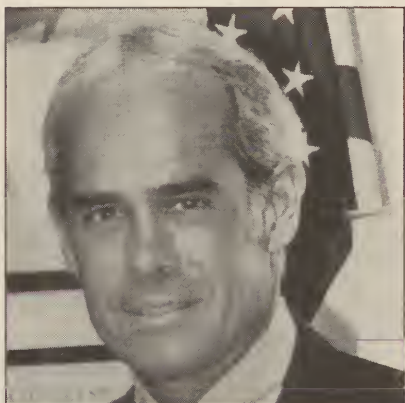
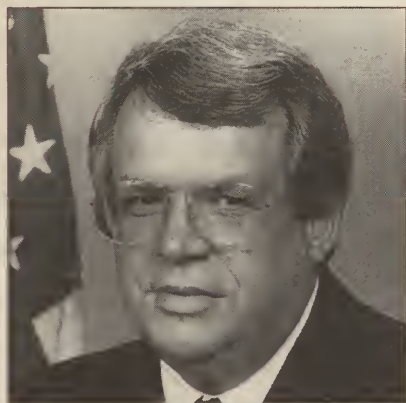
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U.S. Reps. J. Dennis Hastert, John Porter and Richard J. Durbin (clockwise from top left) have actively participated in the health system reform debate. They agree that improved access and cost containment are central to the reform effort. Hastert said antitrust reform would be a "great piece of cost containment."

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EDITORIAL

Practicing common sense

It has been said that some things in life are unavoidable – like death and taxes. This time of year, New Year's resolutions are another inevitable fact of life. But they don't have to be as grim as death or as painful as taxes.

Resolutions are basically just common sense. If we do what we know we should do, we'll have fewer problems down the road. For example, if we talk to our patients about healthier lifestyles, we're practicing preventive medicine, reducing the cost of health care and improving our patients' quality of life.

This year, make it a practice to talk to your patients about lifestyles. If they smoke, help them quit. Every cigarette is stealing time from their life span – seven minutes to be exact, according to the CDC. More than 70 percent of smokers said they would try to stop smoking if advised to do so and if assisted by their physicians, according to the U.S. Department of Health and Human Services. HHS statistics also show that patients whose doctors deliver a brief stop-smoking message are two to 10 times more likely to quit than are other patients.

Are your patients overweight – exercising too little and, like most Americans, consuming a high-fat diet? Explain the potential hazards of their behavior, such as the risk of heart attack, and get them to think twice before they dive into that next pint of Ben and Jerry's.

Talk to your patients about advance directives as a routine part of patient care. These discussions should first take

place in our offices, not when patients are admitted to the hospital. Proper advance directives should address who will make decisions if a patient becomes incompetent and what those decisions should be. To help you counsel patients, ISMS has published "A Personal Decision," a document that explains the options and provides the tools to execute a living will, durable power of attorney and organ donation. You can order copies to distribute to patients by calling (800) 782-ISMS or (312) 782-1654, ext. 1221.

Indigent care clinics are opening in various parts of the state, thanks to the hard work of physicians and other concerned individuals. If you don't live near such a clinic, make it a point to provide some free care on your own this year.

Finally, stay up to date on health system reform. Several bills are under consideration in Congress, and a state legislative subcommittee is compiling information in preparation for state health reform. As you know, reform will have a tremendous impact on our patients and the way we practice medicine. ISMS is conducting town meetings as forums for sharing views on reform. Try to attend and encourage your patients to go as well. The times and places are listed in the story on page 8 of this issue.

The great thing about these resolutions is that after you've done them, you and your patients will feel better. And remember, what's good advice for our patients is good advice for us, too.

PRESIDENT'S LETTER

Testifying on your behalf on reform

By Arthur R. Traugott, MD



Bureaucrats are in essence practicing medicine and placing bottom-line interests above what physicians and patients believe to be good, sound medical care.

On Dec. 1, I testified on behalf of ISMS members before the Senate Democratic Task Force on Health Care Reform. This group, which includes senators and public members, is studying national health system reform to provide input at the national and state levels. As part of its research, the task force requested comments from ISMS. In my testimony, I made the following points.

The president's Health Security Act seeks to offer all Americans a basic benefits package that includes cost-effective preventive care. There is no question that we need to increase the number of primary care physicians practicing in underserved areas. But we disagree with the president's approach, which includes setting quotas on the number of training positions in each specialty. ISMS is currently developing recommendations to improve access to primary care, and we are part of the Joint Task Force on Family Physician Shortages.

In the future, patients may not have the luxury of seeking specialty care anytime they choose and the absolute freedom to choose their physicians. But that freedom is essential to preserving the doctor-patient relationship, which is at the heart of quality care.

To ensure that management decisions reflect patient needs and not just cost, managed care will require vigilance on the part of physicians, patients and public officials. In many insurance utilization review programs, bureaucrats are in essence practicing medicine and placing bottom-line interests above what physicians and patients believe to be good, sound medical care.

By calling for artificial caps on increases in health insurance premiums, the president is limiting health care spending – an indirect "global budget." If health care spending is restricted to an arbitrarily set limit, rationing may become more severe. And eventually, there may be significantly less high-quality medical care.

At the hearing, I was asked whether our opposition to global

budgets extends to a lack of fiscal restraint at the state level. It certainly doesn't. We do not have a laissez-faire attitude about health care expenditures at the state level. But we do see the inherent danger in insurance caps and their effect on patient care.

Restricting funding for medical care will not control the public's appetite for the newest, best and most convenient treatments and technologies. Nor will it end the growing needs of our aging population. Instead, ISMS recommends other solutions. We support insurance reforms such as using modified community rating instead of risk rating and eliminating pre-existing condition clauses.

Peer review is another element of cost control. Physicians have long advocated aggressive peer review, but for this to become a reality, federal and state antitrust laws would have to be changed. So far, we are sorely disappointed by the president's failure to address this issue.

By encouraging patients to adopt healthy lifestyles and practice prevention, we can contain costs. Specifically, we propose that insurance premiums be partially based on behavior and that consumers bear some financial responsibility for their health care.

Finally, we must aggressively reform the malpractice liability system. In Illinois, we already have the certificate of merit requirement, as well as a limit on plaintiff attorneys' fees. To help reduce defensive medicine and stabilize direct malpractice expenses, we must achieve a \$250,000 cap on noneconomic damage awards.

Someone asked me why we're criticizing the Clinton proposal. Organized medicine – representing grass-roots physicians – did not play a major role in Hillary Rodham Clinton's task force. After we were labeled as a special-interest group, we had little opportunity to provide essential input. ISMS believes reform should touch every part of the system, and we've offered solutions for those areas. If patient care is sacrificed through reform efforts, our entire society loses.



"All I ask, Doc, is that you keep me alive long enough to watch Super Bowl 100."

GUEST EDITORIAL

Physician input helps parameters assure quality care

By James S. Todd, MD

The highest priority of our profession is delivering quality care to our patients. Quality is the basis for patient trust.

If practice parameters are based on the best available scientific and clinical information and are compiled by knowledgeable people in the clinical areas involved, these guidelines are among the best tools we have to help maintain and improve quality of care.

In fact, the AMA sees practice parameters as an essential part of overall health system reform. In 1990, we incorporated them into our health system reform proposal, Health Access America. We also recognize that practice parameters can play an important role in continuing medical education, quality assurance, utilization management and managed care. They also offer practical solutions to important professional liability issues.

Parameters should not dictate medical decisions. They should not be a straitjacket for physicians. Rather, they should help physicians identify treatment options as they manage the care of patients. Because all patients are different, flexibility is essential.

The way we implement practice parameters is also crucial. Physicians must be involved in every decision about their use.

Blue Cross and Blue Shield of Illinois' recent application of parameters, or "clinical practice guidelines," is of great concern to the AMA. BCBSI adopted these parameters without seeking local physicians' input. Adherence to these guidelines is part of BCBSI's contractual agreements with physicians. Under these agreements, physicians must follow guidelines for bypass surgery, balloon angioplasty, blood transfusions, cholecystectomies and certain cancer treatments.

If third-party payers act alone in selecting and applying parameters, there may be conflicts of interest stemming from their desire to control costs. As a result, quality may suffer, and patients may be harmed.

Unilateral imposition of practice parameters by insurance companies, without physician input, is unacceptable.

The AMA has used its resources to alert physicians and capture the attention of other managed care organizations that are considering adopting parameters. Our concerns were cited in the local and national press. In addition, *American Medical News* published a story about BCBSI's actions.

The AMA and state medical societies stand ready to work with organizations that are considering implementing practice parameters. Accurate information, effective input and cooperation are vital to the quality of care.

Practice parameters developed without adequate physician input may not be accepted by practicing physicians as clinically appropriate. Insurers should take advantage of the kinds of information medical societies can provide. Medical societies offer the broad-based representation necessary to ensure that practice parameters are scientifically sound, clinically reliable and acceptable to physicians.

The AMA will continue to provide information about practice parameters. We will also assist state medical societies, specialty societies and individual physicians in their efforts to protect quality.

The coming health care environment requires cooperation. We are moving into a new health care era, one in which

increasingly business-minded administrators will try to place cost controls on a par with quality of care. For patients' sake, it is imperative that physicians play a central role in decisions regarding medical care. Ensuring quality is every physician's responsibility.

We should embrace appropriate practice parameters, because there is significant proof that they benefit patients. They can help us give our patients the most appropriate, necessary and cost-efficient treatment possible.



Dr. Todd is executive vice president of the AMA.

GUEST EDITORIAL

Will Clinton stick to his guns?

By David Warsh

The following is reprinted with permission from the Boston Globe.

President Clinton has won a couple of close votes by converting to the opposition's view, and as a result he's riding high. In the budget debate, he took his cue from Ross Perot's 20-percent showing in the election and made a stab at cutting the deficit, keeping Democrats in line. On NAFTA, he followed George Bush's lead and got enough Republicans to vote with him to carry the day. In each case, he was moving to the middle.

Now he is facing the real test on health care. If he follows Rep. Jim Cooper (a conservative Democrat from Tennessee) and the coalition he is building with Sen. John Chafee (a liberal Republican from Rhode Island), he will win. A very successful domestic presidential first term it will have been. If he sticks with his own plan, he will lose.

It's a very painful choice, because it involves his and Hillary Rodham Clinton's deepest visions of the kind of country in which they want to live. It involves as well a calculus of what is possible in politics.

Even before he was sworn in as president, Clinton fired the economists who were telling him that universal health care couldn't be achieved without a considerable tax increase.

He put the issue firmly on the agenda and instructed Hillary and Ira Magaziner to come up with a plan. So far so good: Solving problems is, historically, what people expect a Democratic president to do.

What the team brought forth, however, was a plan for a new universal entitlement sponsored by the government, with little visible connection between benefits and costs.

It's a free country, the Clinton plan announces – and free means you don't pay. Somebody else will.

What has emerged from the Cooper and Chafee plans is quite different: a vision of health and health insurance as a matter of personal responsibility. The role of government, they say, is to see that people can and do buy suitable insurance at a fair price – not to tell them how much to purchase, or to obfuscate the cost.

If the Clinton plan hasn't exactly come into focus for you yet, that's because behind its promise of cradle-to-grave security, it is full of sleight of hand.

All citizens would be guaranteed a comprehensive benefit as deep as is offered today by the most generous corporate plans, but overall costs wouldn't rise much, the architects say, because efficient government claims processing would squeeze the fat out of the system.

Likewise, mandates on employers to pay for insurance would ensure that health care remained tied to jobs – but most real decision making about care standards would be vested in government boards, ensuring that big corporations would continue to do their most crucial lobbying in Washington, rather than directly with the companies from which they purchase health care services.

The Clinton plan is what everybody says it is, a Rube Goldberg contraption designed to make government fundamentally responsible for health care, with global budgets and price controls: in other words, a mess.

The Cooper and Chafee plans repose a good deal more confidence in familiar market mechanisms, though each raises questions it cannot yet answer satisfactorily.

In the Cooper plan, government would simply guarantee the right to buy at a fair price a standard acute-care benefit plan.

Government would provide subsidies to the poor and unemployed, consistent with their income: No one who wanted coverage would go without it.

Note, however, that universal coverage wouldn't be achieved, at least not all at once. No one would be required by Cooper's bill to buy the basic plan – though the treatment they received from doctors or at the hospital would depend on whether they did. Everything, including decisions about whether to purchase supplemental policies, would be optional.

The Chafee proposal differs mainly in requiring all people to buy some coverage, as drivers are required to buy a basic auto-insurance package in most states. In that way the "universalization" battle cry is upheld.

Both plans are alike in that they build on the system we already have, rather than seeking to achieve a wholesale restructuring of the insurance industry, as the Clinton plan does.

Granted, these are just the barest bones of the differences between the Clinton approach and the Cooper-Chafee plans. But what a difference it is!

The Clinton plan reads as if the disappointments of the 1970s, with big government schemes of the New Frontier and the Great Society, had never happened. The Cooper and Chafee plans build on the hard-won deregulatory sophistication of the 1980s.

Of course, there are other plans on the table: the single-payer approach of the most liberal Democrats; and the laissez-faire proposals of conservative Republicans, as propounded by Sen. Phil Gramm. But the Clinton and Cooper-Chafee bills command the middle of the road.

So the real question is whether Clinton will cling to his plan, which he clearly sees as a kind of regulatory "middle way" between administration and the market, or build a coalition with the forces of the New Democrats in Congress, who in turn are eager to build their bridges with Republicans. Universal access? Or universal entitlement? On this distinction depend his chances for success.

The decisions on how to proceed are being made at the White House. The turning point will come when they begin to put together a "war room" on the model of the command posts that helped win the budget and NAFTA campaigns.

The appointment of the New York lawyer Harold Ickes as the head of such an operation would clearly signal that the Clintons were moving to the left, hoping to stitch together a coalition of those committed to universal coverage.

Certainly this is plausible. Something like 90 people in the House are lined up for a single-payer system, which is the penultimate in government regulation. (Drafting all the doctors is the last step.)

Another 100 say they support Clinton. That's close, but there will be no cigar. If the president sticks by his guns, he'll take a long, slow pounding – and he'll lose.

ISMS town meetings to foster health system reform dialogue

Illinois physicians, patients, community leaders, and business and insurance representatives will be able to share their views on health system reform during upcoming ISMS town meetings. To date, four meetings are scheduled: Jan. 26 in Chicago, Feb. 3 in Springfield, Feb. 10 in Rockford and Feb. 16 in Marion. All of the forums begin at 7 p.m. They are free and open to the public. In each area, the events will be co-sponsored by the coun-

ty medical society.

ISMS physician leaders called for the town meetings as part of the Society's Health Reform: Taking Charge of Change campaign. The forums will allow Illinoisans to express their expectations for reform.

"Because physicians are the direct link to patients in our health care system, we feel a unique responsibility to help frame a system that guarantees access to quali-

ty medical care for everyone," said ISMS President Arthur R. Traugott, MD. "The feedback we receive from these meetings will be an invaluable resource for us in achieving this task."

Each town meeting will begin with an ISMS-developed audiovisual presentation on reform, followed by short presentations by each panel member. Most of the program is allotted to audience questions, comments and feedback.

The first meeting will be Jan. 26 at Mather High School, 5835 N. Lincoln in Chicago. The program moderator will be Ald. Patrick O'Connor, who represents Chicago's 40th Ward. Among the scheduled panelists are ISMS President-elect

Alan M. Roman, MD, and Chicago Medical Society President Sandra F. Olson, MD. Other panelists include Edward Cucci, president of Swedish Covenant Hospital; Ray Werntz, a member of the Health and Medicine Policy Research Group board of directors and the Illinois Health Care Cost Containment Council; George Duczak, president of Health Reform Coalition Inc., an insurance purchasing alliance; and Victor Bumagin, a training consultant for the American Association of Retired Persons.

ISMS' Springfield town meeting is slated for Feb. 3 at the Springfield Renaissance Hotel, 701 E. Adams. Jack Connors of WICS-Channel 20 will moderate the discussion. The evening's panelists include Jane L. Jackman, MD, ISMS trustee and Sangamon County Medical Society president; Sen. Karen Hasara (R-Springfield); Michael Boers, executive director of the Greater Springfield Chamber of Commerce; Richard Carlson, chief operating officer of St. John's Hospital; and Don Moss, a lobbyist representing individuals with mental, developmental and physical disabilities.

For more information about the town meetings, call ISMS at (312) 782-1654 or (800) 782-ISMS, ext. 1243. Watch future issues of *Illinois Medicine* for continuing coverage of all four town meetings and other ISMS health system reform activities. ■



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EHS, UIC approve affiliation

[CHICAGO] In November, the University of Illinois Board of Trustees announced approval of a master affiliation agreement with EHS Health Care, which owns five Chicago-area hospitals. The board also endorsed a subordinate affiliation between the University of Illinois at Chicago College of Medicine and EHS Christ Hospital and Medical Center in Oak Lawn.

Under the master agreement, EHS will be linked with the U of I Hospital and Clinics as well as the university's colleges of associated health professions, dentistry, nursing and pharmacy and the school of public health, UIC officials said. The medical school affiliation designates EHS Christ Hospital as the primary training site for UIC's undergraduate and graduate education, research and faculty practice.

"I'm delighted that EHS has chosen us for this affiliation," said Gerald S. Moss, MD, dean of the UIC College of Medicine. "This will be a powerful partnership, bringing together an excellent health care provider and a university that is dedicated to the most advanced medical education, patient care and research."

The new affiliations will enhance UIC's emphasis on primary care training, said Richard R. Risk, EHS president and chief executive officer. "EHS anticipates an increased need for well-trained primary care physicians, and UIC's College of Medicine educates these physicians, making the affiliation extremely beneficial for both parties."

Over the next several years, the UIC College of Medicine will phase out its affiliation with Illinois Masonic Medical Center, which is developing a similar arrangement with Rush-Presbyterian-St. Luke's Medical Center, officials said. UIC currently places about 150 residents at Illinois Masonic. Officials expect the university will place a similar number of residents at EHS Christ. ■

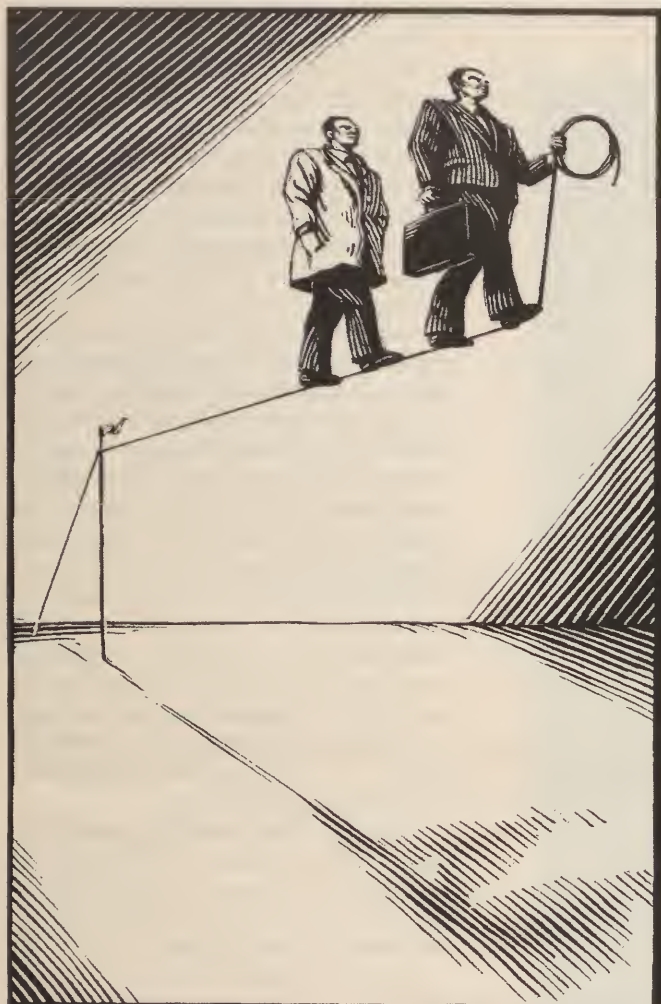
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ISMIE Update

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reduction tail
for new
physicians

PAGE 10



Bob Dahm

Defensive medicine vs. managed care

Physicians face increasing pressure to protect themselves, their patients and the bottom line. By Kathleen Furore

There was a time when Edward J. Fesco, MD, paid only \$25 per year for malpractice insurance, distributed samples of antibiotics to his patients who couldn't afford prescriptions and did not feel pressured to order a CT scan or an MRI for every patient with a headache. But not anymore. Today, the general surgeon — who practices in Peru and Spring Valley and is a member of the ISMIE Risk Management Committee — pays substantially more in malpractice premiums and, like his peers, practices medicine more defensively.

"I would say that virtually every physician I know practices so that no one can say, 'You didn't order something

that you should have,'" said Dr. Fesco. The pressure to practice defensive medicine escalated when juries began awarding damages for pain and suffering as well as for lost wages and medical expenses, he added. "More and more people are taking doctors to court with the expectation of getting a large bit of money that is tax-free. And doctors are extremely worried that should they have a misadventure and the pain-and-suffering lottery clicks in, they'll be ruined."

Of course, the threat of being named in a lawsuit has always existed. But as litigation has increased, damage awards have risen and the focus of reform has shifted to managed care, physicians are facing more pressures

than ever to provide optimal patient care while protecting themselves and the bottom line. Consequently, they must try to juggle mutually exclusive goals.

"Managed care and defensive medicine are not natural allies," said Richard A. Geline, MD, a Chicago orthopedic surgeon and also a Risk Management Committee member. "It's a squeeze play. You're pressured to practice defensive medicine, which means ordering more tests, keeping patients around [hospitals] longer. It means being as conscientious as possible, calling in consultants, filling out charts and gaps in patient records so that nothing is missed anywhere. But managed care means reduced care —

(Continued on page 10)

MALPRACTICE ROUNDUP

Court OKs disclosure of physician's HIV status

In the first case testing Pennsylvania's 1991 AIDS confidentiality law, the state Supreme Court ruled in favor of two hospitals, according to *Medical Malpractice Law & Strategy*. The law prohibits health care providers from disclosing HIV test results to anyone other than the patient without a court order and stipulates that such an order may be issued only if there is a compelling need for disclosure.

The two hospitals were sued after holding a news conference, issuing a press release and mailing letters to 447 patients to announce that a physician had tested HIV positive. Although the hospitals did not reveal the physician's identity to the public, they did identify him to his colleagues, so that the physicians would inform the doctor's surgical patients about their potential exposure.

The court ruled that the hospitals had a compelling need to inform the patients and that the limited disclosure to other physicians balanced the patients' right to know with the doctor's right to privacy. ■

Implant physicians sued for fraud

A New York trial judge recently dismissed a case against a physician who was sued for fraud and fraudulent concealment by a patient who had received breast implants. The plaintiff claimed that the physician misrepresented the safety of implants and alleged that the procedure led to her symptoms of fatigue and muscular pain and a ruptured implant. But the judge ruled that "there was no claim of fraud separate and distinct from the alleged malpractice and lack of informed consent," and the statute of limitations for medical malpractice had expired.

According to *Medical and Legal Aspects of Breast Implants*, this ruling could affect other breast implant claims — many filed by plaintiffs who had surgery in

the 1970s and early 1980s — that are barred by the statute of limitations. Generally, the statute of limitations for malpractice begins when the patient is treated or diagnosed, not when the injury is discovered.

To sidestep those limitations, some plaintiffs are filing claims alleging fraud or fraudulent concealment under discovery statutes. These laws allow actions to be filed "within two years of the discovery of a fraud or six years from the commission of the fraud, whichever is longer." Such fraud claims are especially suspicious if the injuries are the same as those that would result from malpractice or if the fraud is actually a claim of lack of informed consent. As in the New York case, plaintiffs are claiming that physicians misrepresented the safety of implants. ■

Physicians liable for patient follow-up

The Letter, a publication of the Louisiana Medical Mutual Insurance Co., explains why physicians should develop follow-up procedures for patients referred to specialists. After preliminary tests indicated a patient might have multiple myeloma, physicians practicing in a California group referred the patient to an oncologist. The patient did not keep the appointment but continued treatment with the California group for other problems.

Two years later, the physicians again referred the patient to an oncologist, who diagnosed multiple myeloma. By this time, however, the patient was experiencing renal failure. He died three months after being diagnosed. The patient's widow sued the group, and the jury awarded the plaintiff \$421,600.

The jury accepted the plaintiff's claim that the defendant physicians failed to explain the seriousness of the initial test results and the importance of seeing the oncologist. The jury also said the physicians did not use adequate follow-up procedures for monitoring patient compliance with referrals. ■

Defensive medicine

(Continued from page 9)

getting by with the minimum. It has the potential to be a real problem; it depends on the structure of the managed care organization."

The increase in the number of tests ordered is perhaps the best indicator that the practice of defensive medicine is climbing. Dr. Fesco said he believes that between 20 percent and 25 percent of all tests are ordered because of defensive medicine.

Another member of the Risk Management Committee, who is an Ob/Gyn in Evanston, agrees. "I think physicians are depending a lot more on high-technology tests, which are very expensive, before they will proceed to a management plan," said David W. Cromer, MD. "Some are justified, but some are probably related to this whole scene we're talking about," he added, referring to what he calls defensible medicine. Dr. Cromer cited the example of the use of ultrasounds, especially in low-risk pregnancies.

"Does everybody need an ultrasound, and how many ultrasounds does the low-risk individual need?" he asked. "In our particular business, it's the area of most concern, not only in terms of costs but of exposure to tests."

But cost — more specifically, cost containment — is at the heart of managed care, which means physicians are being pushed to prove they can provide high-quality care while effectively managing the cost of that care. Throw in the pres-

sure to practice defensive medicine, and the Catch-22 is clear.

"In the current climate of cost cutting, cost control and health care reform, defensive medicine becomes even harder to practice. If you do what you need to do to protect yourself malpractice-wise,

Right now, it's sort of a jackpot kind of thing. If lawyers say the right words in front of the right people and the jury agrees — kaboom — three cherries come up!

you jeopardize yourself in the cost-control arena," Dr. Geline observed.

To illustrate his point, he cited a theoretical case: "Say the government pays \$5,000 for a hip fracture, whether the patient stays [in the hospital] five days or five weeks. If you have a doctor who's very careful and practices defensive medicine and keeps the patient in the hospital because he wants to watch the patient, it's costly for the hospital. Suddenly, their cost to deliver care to your

patient is higher than the allotment, and that will show up. Pretty soon, they're going to say, 'Gee, doctor, the way you practice medicine is too expensive. We're losing money on all your patients.'"

Dr. Fesco, too, expressed concern over the tendency to limit hospital stays in a managed care environment. "That's the most disturbing thing I've seen so far in managed care. I think the length of stay has decreased by at least one-third overall, and in [my] business, it has decreased even further. Obstetric stays are down in many plans by many insurers. There's a trend toward a 24-hour stay for vaginal deliveries, and for some cesarean sections, it's just another day; it used to be three days for vaginal deliveries and five days for c-sections."

That trend makes it difficult to provide care and patient education to mothers and their newborns, Dr. Fesco said, adding that studies have shown that women don't absorb much information during the first 12 to 24 hours after delivery. "There's a big scramble now to find a cost-effective way to render this patient education, either before or after delivery," he noted.

Dr. Geline added that there is irony in the fact that lawsuits, which may result from the failure to practice defensively, are "potentially more malignant" than ever before. "The question, Have you ever been sued? creeps into all kinds of applications now. It's asked every time you apply or reapply to a hospital staff or apply to be a consultant or member of an HMO, PPO or managed care organization," he said. "Win, lose, draw, settle or drop, the fact is you have a mark on your record. And even though the presence of a lawsuit is only testimony as to how easy it is to initiate the process, [a suit] has the potential to be a negative mark on your record. It can have repercussions on your ability to make a living if you want to join an organization and can't. It's a problem that's very worrisome, very real."

AND SO THE QUESTION becomes, Is it possible to provide high-quality care, practice defensive medicine and live in harmony with managed care? While there are no easy answers, the physicians who spoke to *Illinois Medicine* said it is possible under certain circumstances.

One condition that must exist, according to all three doctors, is caps on noneconomic damages in civil cases, including malpractice lawsuits. Caps are essential to curb costs and control the testing prompted by excessive litigation, they said.

"Caps are the goal of the Illinois State Medical Society, and they remain the primary goal of all organized medicine that I know of," said Dr. Geline.

"Right now, it's sort of a jackpot kind of thing," Dr. Fesco added. "If [lawyers] say the right words in front of the right people and the jury agrees — kaboom — three cherries come up!"

"I think caps are necessary to demonstrate good faith on the part of the legal system that it's going to try to keep these things under control," added Dr. Cromer.

To help establish the types of visits and basic tests for particular disease conditions, clinical practice guidelines are in the works, according to Dr. Cromer. However, he cautioned that such guidelines must be predicated on substantial input from practicing physicians and organized medicine. "These kinds of guidelines are critical for a managed care system to work, to enable doctors to provide the best quality patient care while keeping costs down. I think if these are in place, they will give a lot of assistance in basic care and will not only help reduce costs, but may also help bridge the gap [between defensive medicine and managed care]."

Finally, Dr. Fesco said that to balance the pressure to practice defensive medicine with the edict to administer cost-effective care, doctors may need to be selective in ordering tests. ■

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POLICYHOLDER NEWS

Exchange waives class reduction tail for new physicians

In November 1993, the Illinois State Medical Insurance Services board of directors adopted policy allowing newly practicing physicians up to five years to request a class reduction tail waiver. When policyholders ask to lower their rating classification, they must purchase a class reduction tail. The Exchange exempts physicians from purchasing this tail coverage if they are over age 55 and have held ISMIE policies for five years or if they are newly practicing physicians and notify ISMIE before the five-year period expires. Physicians must provide evidence that they have not performed any of the procedures that resulted in

their higher class rating.

"Residents often come out of training and enter private practice with high expectations of the types of procedures they may be called upon to perform, but they may never actually do them," said Alfred J. Clementi, MD, ISMIS board chairman. Physicians' insurance rating classes are based on the kind of procedures they perform as well as their trained specialty, he explained. "In the spirit of the Physician-First Service initiative, the board has established the five-year period for requesting retroactive class changes and additional charge waivers for physicians in their first five years of practice." ■



How to prepare for a deposition

by Rea Boylan Mabon

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The purpose of a discovery deposition is to find out as much information as possible. Specifically, it is the lawyer's obligation to pin down witnesses as to their recollection of events. Consider the following 10 guidelines as you prepare for your deposition.

Before the deposition

1. Prepare an updated copy of your curriculum vitae and review it so that you are familiar with it. Pay particular attention to experience that relates to any specialty involved in the case. You should consult your attorney about whether or not you should bring the curriculum vitae to the deposition itself.

2. Review any documents you have prepared or signed that relate to this case. This would include hospital records, reports, memorandums, telephone messages, statements and court documents.

3. Meet with your attorney before the deposition to prepare. If you are not a party to the case, you should consult with an attorney regarding whether an attorney should attend the deposition with you.

4. Review the plaintiff's complaint and the defendant's answer so that you understand the issues in the case.

5. Review the sequence of events that occurred. Be clear as to why you made decisions at different times. For example, if you ruled out a diagnosis, it is important for you to be able to explain why you did so. Witnesses are often asked about information they did or did not have before acting or making a decision.

At the deposition

6. Wait until a question is completed before giving your answer. If you begin to answer a question before it is completed, the record may become unclear. In addition, you may give an answer that is not appropriate for the question asked.

7. Answer only the question that was asked. Listen carefully to the attorney's question and give only the information that is requested. The parties will have an opportunity to present additional information at trial if it is required. By giving additional facts in your answer, you may open yourself up to being asked questions that otherwise may not have been asked. For example, do not answer a question about what you saw by giving information about what you heard.

8. Make sure that the question is clear and accurate before you give an answer. If you do not understand the question, you may ask the attorney to rephrase it.

In addition, if a fact in the question is inaccurate, you should correct that fact before giving your answer.

If you are asked a compound question, you must be careful to answer both parts of the question or you should ask to have the question rephrased. If you give only one answer to the compound question, the answer on the record may be confusing.

9. Take a break or ask to confer with your attorney. This is a particularly

good idea if you become tired or frustrated with the deposition. If you become emotional, you will not be thinking clearly. If your answers appear hostile, you may come across as an advocate for a particular position instead of as a person who is simply telling the truth.

10. Don't answer a question with a guess. You may give an estimate, but you should identify it as an estimate. If you

guess at an answer, you increase the likelihood that you will later be shown to be inaccurate or inconsistent. You should continue to say that you do not know the answer to a question if that is the case, even if you are asked the question several times. It is easier to explain to a jury why a fact is unknown or forgotten than why a witness is inconsistent.

Your attorney should be able to assist you in anticipating areas of testimony that are critical, difficult or confusing. However, the key to giving a good deposition is concentrating on giving accurate and truthful answers. Preparing for your deposition by following these guidelines should allow you to do just that. ■

ISMIE offers deposition video

An Exchange-produced videotape, "The Physician Defendant: Your Deposition," is available on loan to all ISMIE policyholders. The video explains the function of the deposition process and provides tips on how to prepare for a deposition. To borrow the tape, physicians may contact the Exchange risk management department at (800) 782-ISMS, ext. 1327, or (312) 782-2749.

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TORT REFORM

Illinois Civil Justice League battles for change

A liability reform forum reveals a crisis in two Downstate counties.

BY ANNA CHAPMAN

Caring for critically ill patients has become an economic and emotional hazard for physicians in St. Clair and Madison counties, according to area physicians and defense attorneys. Some doctors have retired early, and others have left southwestern Illinois because they feared the local court system, in which plaintiffs in malpractice suits have seemingly unlimited control over the judiciary.

James V. Vest, MD, is one physician who has stayed in St. Clair County, but he has serious concerns about his ability to practice critical pulmonary care in the area. Even though no malpractice suit had been filed, Dr. Vest and his attorneys were jailed last year after a deposition in which he refused to answer a plaintiff attorney's question regarding his treatment of a patient who had died. The Illinois Supreme Court later found that Dr. Vest and his attorneys should not have been held in contempt of court.

Dr. Vest told his story in Collinsville during a Dec. 2 community forum sponsored by the Illinois Civil Justice League and one of its members, the Southwestern Illinois Industrial Association. Through a series of public forums to be held around the state, the new coalition intends to educate the public about the high cost of frivolous or "junk" lawsuits, said league president Ed Murnane.

To work toward reforming the liability system in Illinois, the league was formed late last year by organizations representing local government entities, nonprofit organizations and entrepreneurs, as well as small and large businesses and associations, coalition officials said. League members, including ISMS, assert that the out-of-control court system increases costs for consumers and taxpayers. Such costs surface as hidden taxes on all products and services sold in Illinois, according to the league. Murnane said the coalition will explore tort reforms such as instituting caps on

noneconomic damages, ending frivolous lawsuits and changing product liability laws.

"For years, tort liability reform has been an important issue in Illinois," Murnane said. "It's one that rears its head in the legislature every few years, but for many years it has been viewed as a battle between the Illinois Manufacturers Association and the insurance industry or between the Illinois State Medical Society and the Illinois Trial Lawyers Association. It's been fought at a level where a lot of people have said, 'Let the wealthy doctors and wealthy lawyers fight it out; it doesn't really affect us.'

"The fact of the matter is, it does affect all of us," he



Maureen Houston

If the malpractice climate were different, we certainly would not order as many tests as we do.

— Dr. Hamilton

TORT REFORM



Maureen Houston

I, as a physician, worry about whether I should get on the phone to ISMIE and say, 'I've got another bad one. Here we go again.'

— Dr. Vest

continued. "What we're hoping to accomplish through this and the remaining forums is to let people understand that this is a problem that has a very profound impact on every aspect of our lives."

FORUM PARTICIPANTS explained the liability challenges faced by the groups they represent. Nancy Hickman, executive director of the Shagbark Council of the Girl Scouts of America, discussed the difficulty that liability risks pose in securing recreation facilities for the scouts. David Oates, president of Oates Associates Inc., an engineering and architectural firm, said his company is at high liability risk even though injuries are seldom caused by a structure's faulty design. And Steve Balen, superintendent of Granite City schools, explained that it is often cheaper to settle personal injury cases than to try to prove that "you tripped, you were on the playground and you were really injured."

Two state senators — Frank Watson (R-Carlyle) and Ron Stephens (R-O'Fallon) — also participated in the forum and stressed the need for coalitions like the Civil Justice League. "The reason I'm here is that I believe in what you're doing," Watson said, praising group members for tackling a problem that could be insurmountable if they approached it individually.

"I'm excited because what I hear today is that we're not talking about cutting off benefits to anyone who is injured or otherwise inconvenienced," Stephens said. "We're not talking about taking advantage of the plaintiff's attorney. What we're talking about is creating a level playing field. [Coalition members] have repeatedly related to me that all they want to do is have an opportunity to express fairness in the courts of Illinois. And that is evident nowhere more than in St. Clair and Madison counties."

Dr. Vest and the other physician participants also expressed their desire to restore fairness to the legal system. "The point I want to make is that every time I go to the hospital at two or three in the morning, I, as a physician, worry about whether I should I get on the phone to [ISMIE] and say, 'I've got another bad one. Here we go again.'"

Belleville neurosurgeon Michael G. Murphy, MD, said he is a frequent visitor to the city's courthouse.

"The trial lawyers have seized the courthouse from the people. We have to take it back from them," he said.

Defense attorney Larry Hepler said specific legislative reforms could be enacted to create fairness for defendants without overhauling the entire system. As an example, he cited changing the so-called Petrillo doctrine, which gives plaintiffs unfair advantages in malpractice cases.

"All we're trying to do in the defense bar is to level this playing field," Hepler said, adding that the income of defense lawyers is not affected by the size of verdicts. "We in the Illinois Defense Council are attempting to find areas in which we could take some of these rules and cases and laws and try to level the field. That's what I think an organization like this can do."

"IT'S A MAJOR problem in many areas for insurance companies to get reinsurance," said Robert F. Hamilton, MD, an Alton surgeon and ISMS Sixth District trustee. That was the situation in 1975 when ISMIE was formed, Dr. Hamilton explained. "I'd been in practice two years, and all of a sudden there was no more malpractice coverage." Insurance companies began pulling out of the market because the risk had become too great, he said.

Today, a significant amount of medical costs can be attributed to defensive medicine, Dr. Hamilton noted. "It's a day-in, day-out decision-making process for each individual patient, each test we order, each type of therapy we recommend. If the malpractice climate were different, we certainly would not order as many tests as we do. We do that strictly for protection."



Matt Fergusson

We want people to realize that if we're going to correct this problem, we're going to have to educate legislators and the voters.

— Murnane

Dr. Hamilton said capping noneconomic damages in medical malpractice suits could significantly reduce the cost of medical care. In addition, states that have enacted caps have stemmed skyrocketing malpractice premiums. California is one example. "In California's physician-owned companies, the costs have dramatically decreased," he added. "In some cases, the costs may be half of what I pay."

But caps and other reforms cannot be implemented without a broad-based effort, Murnane said. And the coalition plans to make tort reform a "serious major issue in all of the campaigns in Illinois in 1994."

"We want people to realize that if we're going to correct this problem, we're going to have to educate legislators and the voters," he continued. "We do have to bring about a mind-set change in Springfield to enact the kinds of reforms that we feel are necessary." ■

Northwestern joins NIH 'Women's Health Initiative'

GRANT: Illinoisans will be included in a 13-year nationwide prevention study. By Anna Chapman

[CHICAGO] Northwestern University Medical School announced last fall that it is participating in the new 'Women's Health Initiative' conducted by the National Institutes of Health. As one of 16 clinical centers chosen for the study,

Northwestern was awarded a \$12-million research grant. The study is aimed at identifying ways to prevent heart disease, cancer and osteoporosis in postmenopausal women, said Philip Greenland, MD, chairman of Northwestern's

preventive medicine department and principal study investigator.

The study is especially significant because only limited research on women's health issues has previously been conducted, Dr. Greenland said. One reason for this discrepancy was that men had been shown to be at greater risk for diseases common to men and women, such as heart disease, he added. In addition, test results for men could be obtained quicker and less expensively.

However, Dr. Greenland said collecting test results on men and assuming those results are equally reliable for women is a naive scientific conclusion. "We've come

to learn that there are differences and that there are therapies that may work in men and may not work in women."

He also said there may be scientific biases against women, especially in the area of drug treatments for menstruating women. But he added there are ethical questions about including women in drug trials if there is a possibility they could become pregnant. "Is it ethical [to use a treatment] if the effects on the fetus aren't known? It's a subtle bias, but the result is excluding women."

More than 160,000 women across the country, including 4,000 from the Chicago area, are expected to participate in the 13-year study, Dr. Greenland said.

"We're all exceedingly excited and proud of the achievement here," said David H. Cohen, Northwestern University provost. "The Women's Health Initiative, sponsored by NIH, is really a massive effort, the largest clinical trial in the nation's history. It is motivated by a recognition that biomedical research hasn't adequately addressed studies of women and their health issues. It reflects an important and overdue maturation of the health research policy of the nation."

"The importance of population-based studies lies in improving the health of the public," said Harry N. Beaty, MD, dean of the medical school. "We're proud that the NIH recognized that Chicago has the capacity to be a major contributor."

The overall study has two components — clinical trials and an observational study, Dr. Greenland explained. Both will follow women age 50 to 79 for eight to 12 years. Preliminary study results should become available in nine years, he noted. "In a more typical trial studying people who have a disease, you get answers faster. This is a very long-term trial, but it's typical for prevention studies. We're tending to look at keeping healthy people healthy."

Through the observational study, scientists will try to identify disease predictors, Dr. Greenland said. Investigators will also attempt to determine whether women have different risk factors than men for common chronic diseases and whether weight change is a predictor of illness.

In the first phase of the clinical trials, women will be selected to participate in a dietary study, a hormone replacement therapy study or both, Dr. Greenland said. A study of calcium and vitamin D supplementation will begin next year. "There is a substantial portion of participants in both components. The study is designed to make use of overlapping of trials."

Dr. Greenland said Northwestern began recruiting women participants through direct mailings and advertising a hot line in October 1993. Investigators at the Northwestern clinical center, which includes testing sites at Northwestern Memorial Hospital and Evanston Hospital, plan to enroll about 1,270 women in the clinical trials and 2,500 women in the observational study, Dr. Greenland said.

While in the study, each woman will remain under the care and supervision of her own physician, Dr. Greenland said. Doctors will routinely receive updates about their patients' progress in the study, including pertinent lab test results. In addition, patients will always be referred to their own physician if a possible medical or surgical problem is identified during clinical center visits, Dr. Greenland noted. ■

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MEMBERS IN THE NEWS

ISMS member appointed to CHIP board of directors

Gov. Jim Edgar appointed Chicago nephrologist Janis M. Orlowski, MD, to the state's Comprehensive Health Insurance Plan board of directors in November. Dr. Orlowski replaced Joan E. Cummings, MD, director of the Department of Veterans Affairs Edward Hines, Jr. Hospital and ISMS second vice president.

Currently, CHIP provides health insurance for 4,700 medically high-risk individuals who are unable to obtain health insurance from private companies. Those individuals can afford to pay insurance premiums and are ineligible for Medicaid. CHIP was approved by the legislature in 1988 and implemented in 1989 when funding became available. Program enrollment is limited because its funding is derived from premiums and General Assembly appropriations.

In addition to her practice at Rush-Presbyterian-St. Luke's Medical Center, Dr. Orlowski is an assistant professor of medicine at Rush Medical College. She is certified by the National Board of Medical Examiners and the American Board of Internal Medicine, as well



Gov. Edgar named Dr. Orlowski to the state's CHIP board in November.

as its nephrology subspecialty board. She serves on the ISMS Council on Economics and is vice chairman of the Chicago Medical Society Council.

Edgar also made appointments to Illinois' Advisory Council on Spinal Cord and Head Injuries. The new members are Leonard J. Cerullo, MD, of River Forest, and Paul R. Meyer, MD, of Chicago. Dr. Cerullo is a neurosurgeon and serves as medical director of the Chicago Institute of Neurosurgery and Neuroresearch. Dr. Meyer is founder and director of the Midwest Regional Spinal Cord Injury Care System and is a professor of orthopedic surgery at Northwestern University Medical School.

John P. Leonetti, MD, a Lombard otolaryngologist and head and neck surgeon, was one of 37 physicians nationwide to receive the 1993 Honor Award of the American Academy of Otolaryngology-Head and Neck Surgery. The awards were presented last fall during the organization's 97th annual meeting in Minneapolis.

Dr. Leonetti was recognized for his success using an electronic monitoring technique to preserve facial nerve function while removing acoustic neuroma tumors. He serves as co-director of the Loyola University Medical Center cranial-base surgery center and is an associate professor in the division of otology, neurotology and skull-base surgery.

Harry J. Miller, MD, an Evanston hematologist, is the first recipient of the Henry P. Russe, MD, Citation for Exemplary Compassion in Healthcare, presented by the Institute of Medicine of Chicago. Dr. Miller was honored for his "compassion for patients and their families, his inspirational teaching, his service to his fellow physicians and his community," said Margaret Hastings, PhD, Institute executive vice president.

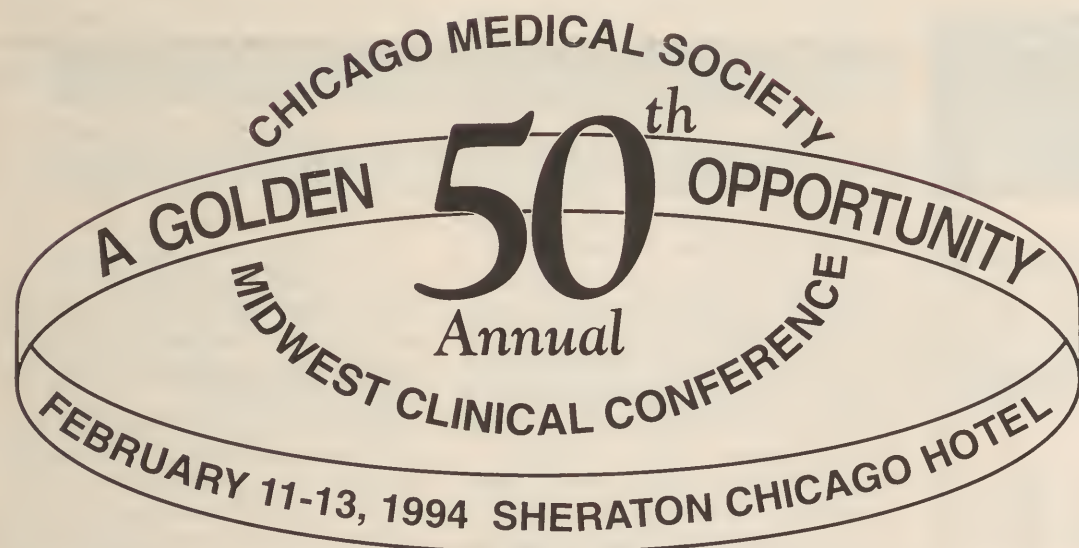
Dr. Miller is head of the division of hematology at Evanston Hospital and founder of Hospice of the North Shore.

In addition to his work at Evanston Hospital, Dr. Miller has been an associate professor of clinical medicine at Northwestern University Medical School since 1976.

The award was established by the Institute to honor the late Dr. Russe, former dean of Rush Medical College and five-time president of the Institute.

Richard A. Prinz, MD, a River Forest general surgeon, has been named chairman of the general surgery department at Rush-Presbyterian-St. Luke's Medical Center. Dr. Prinz is a former professor of surgery at Loyola University Stritch School of Medicine and former chief of endocrine surgery at Loyola. He also served as a consultant in the general surgery section at the Department of Veterans Affairs Edward Hines, Jr. Hospital.

Proceeds from a new book by Lawrence D. Robbins, MD, of Deerfield, will benefit Highland Park Hospital's "Partners in Health" campaign, which is raising funds for the hospital's new surgical pavilion. The book, *Management of Headache Medications*, attempts to clarify various headache treatments and offers practical management techniques.



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BOBBI CHAPLIN, ISMS' director of accounting, was named December 1993 Employee of the Month. Chaplin was nominated for her work during ISMS' annual budget process, during which she helps prepare budget packets for review by physician committees. She also assists in monitoring department budget variances throughout the year.



Carla Sommerfeld

Antitrust

(Continued from page 1)

To distinguish legal joint ventures from anticompetitive ones, such as the home oxygen companies, the U.S. Department of Justice and the FTC released six new enforcement policies in September 1993 outlining antitrust "safety zones" for hospitals and health care providers.

"The statements are designed to help the health care community understand what conduct is and is not permissible under the antitrust laws, and to ensure that misunderstandings about antitrust do not inhibit pro-competitive arrangements," Whitener explained.

The safety zones do not change existing law; instead, they clarify and confirm current policy, he said. "They describe — in a single, authoritative and joint document — the federal agencies' antitrust

analysis of conduct that falls outside each of the six safety zones. They also commit the agencies to expedited review of proposed health care arrangements in advisory opinions or business review letters."

Specifically, the policy statements describe the conditions under which certain health care ventures will not be challenged by the DOJ and FTC, said Gail Kursch, chief of the DOJ antitrust division's professions and intellectual property section. These conditions are hospital mergers, hospital joint ventures involving high-technology or other expensive medical equipment, hospital participation in price and cost information exchanges, joint purchasing arrangements, physician network joint ventures, and physician provision of medical data to purchasers of health care services.

ALTHOUGH THE POLICIES are a step in the right direction, they are far more restrictive

than the antitrust reforms the AMA is proposing, according to Edward Hirshfeld, AMA associate general counsel. The AMA advocates antitrust reforms to facilitate the creation of physician-directed health care networks and health plans and to require physician input into networks and health plans that are not directed by doctors, Hirshfeld said.

The AMA is also seeking antitrust relief to allow physicians to negotiate with government agencies regarding payments and other medical practice issues and to expedite the establishment of standards and peer review by physician-directed organizations. Organized medicine's overriding goal for antitrust reform is to enable physicians to compete on a level playing field with hospitals and insurance companies, Hirshfeld explained.

"Physicians are in a unique position to meet the challenge facing medicine today — the need to find ways to reduce costs without compromising quality," he continued. "The public will benefit from the increased competition that physician-directed organizations will bring to the market, and the public will also benefit from the patient-interest orientation that

physicians will bring to health plans."

Antitrust issues are also important to hospitals, said Jeff Teske, assistant general counsel for the American Hospital Association. "The policy statements are a good first step, especially with respect to the expedited review process. But, clearly, we feel that more needs to be done. We don't believe that [the statements] address all provider concerns."

According to Teske, the AHA is seeking antitrust relief that permits hospitals to form networks composed of various types of providers and that eliminates the need for hospitals to duplicate services.

THE GOVERNMENT does not intend to issue similar policy statements for other industries, Whitener stressed. "[Antitrust] laws are more than flexible enough to deal with conditions in other industries, but there are unique conditions facing health care."

"Health care policy is going to move toward the integrated delivery system everyone has been talking about," Teske said. "And providers need additional guidance from the enforcement agencies [about] how to get these networks going." ■

Task force

(Continued from page 1)

ciation, the Illinois Rural Health Association, Rush Medical College and Southern Illinois University School of Medicine. ISMS Secretary-Treasurer David B. Littman, MD, a Highland Park internist, represents ISMS on the task force.

Albert G. Bledig, MD, a Harrisburg physician who testified on behalf of ISMS, told the task force that family physicians are not the only doctors in short supply in Illinois. Other primary care providers such as internists, pediatricians and Ob/Gyns are also needed. Dr. Bledig said ISMS has asked the task force to develop a clear definition of what constitutes primary care and to include in its deliberations all physicians who provide those services. In addition, the Society maintains that any plan aimed at addressing physician shortages must include tort reform, he explained. In particular, ISMS advocates a \$250,000 cap on noneconomic awards to stabilize the medical malpractice climate and help expand access to care, Dr. Bledig noted.

"Because of the lagging Downstate economy, physicians [there] have the largest proportion of uncompensated care and see a larger percentage of Medicaid patients," he said. "As government and some third-party reimbursements have dropped in recent years, these physicians simply can no longer afford malpractice insurance. So they abandon risky procedures to lower their malpractice costs or they abandon medicine altogether."

According to Dr. Bledig, a 1987 survey of ISMS members revealed that 8 percent had moved their practices to avoid litigation or had stopped practicing medicine. More than half had stopped performing risky medical procedures, and 39 percent had limited their use of newly developed techniques, the survey found.

"I think it is very difficult to practice in a rural area if you don't have the right attitude," said Marcos Sunga, MD, of Roseclaire. "First, you have no support system, especially for Medicaid patients. Specialists always ask if the patient is on public aid."

Dr. Sunga also discussed the pressures applied by peer review organizations performing utilization review on services delivered to patients covered by government health programs. "They expect us to treat rural patients the same way you treat patients in a big hospital with a lot of specialists. They might come in and ask us why we didn't consult a nephrologist. Well, we don't have a nephrologist."

From 1988 to 1991, Dr. Sunga was Roseclaire's only practicing physician and Hardin County Hospital's only admitting physician. He was on call 24 hours a day and ran a full-time clinic. Dr. Sunga said the only way the town could attract another physician was to offer financial incentives. "We advertised constantly for a physician. A few people came for two or three months and then left. Finally, I got a partner, and the only reason he came was because he knew me."

Gail Melendres, a third-year SIU medical student studying family practice medicine, verbalized some of the concerns of medical students considering this area of practice. "I think the scary part is hearing the complaints of other physicians — patient overload, not getting paid, the high cost of malpractice insurance. That's what scares me about going into family practice."

Melendres told the task force she will owe \$60,000 in medical school loans when she graduates, even though she received a full scholarship her first year and SIU waives fourth-year tuition for family practice medical students. She said one of the ways to persuade students to choose primary care is providing financial incentives, including help with loan repayment, loan deferment without interest and assistance with malpractice insurance payments for high-risk procedures.

Rep. David Phelps (D-Eldorado), who serves as co-chairman of the task force, said the committee will use the information it collected at the hearing to help develop recommendations for the General Assembly. A working group is scheduled to meet this month to draft the task force's suggestions, he added. ■

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RBRVS*(Continued from page 1)*

\$33.72; and the nonsurgical, nonprimary care services conversion factor rose 5.3 percent to \$32.90.

Because of the RVU cuts, however, conversion factor increases do not directly reflect reimbursement hikes. For example, in 1993, a Cook County physician received \$3,031 for performing a coronary artery bypass. In 1994, that physician will receive \$3,130 for the same procedure – an increase of only 3.3 percent over 1993 rates.

Through the Omnibus Budget Reconciliation Act of 1993, Congress made additional Medicare changes that will affect physician reimbursement under the new fee schedule, ISMS analysts said. Effective Jan. 1, physicians are being reimbursed for EKG interpretations. Previously, the government prohibited physicians from billing Medicare for interpretations as separate charges. In addition, physicians in their first four years of practice will now receive 100 percent of the payment allowed under the fee schedule; previously those physicians had been reimbursed according to a sliding scale based on their number of years in practice.

THE GOVERNMENT in 1993 also released proposals for new and expanded safe harbor regulations under the Medicare and Medicaid anti-kickback statute. The safe harbors delineate permissible payment practices to be used by physicians, hospitals, clinical laboratories, pharma-

cists and medical suppliers, as well as people who do business with health care providers such as consultants and attorneys. Announced in September, the proposals expand the current safe harbor on investment interests and add new safe harbors covering areas such as physician recruitment, malpractice insurance subsidies and referral agreements. Although the safe harbor proposals provide some guidance for determining which payment

new safe harbors may be considered violations of the Medicare program, Society advisers cautioned. Medicare officials will not question payment practices that meet the requirements of a safe harbor. Individuals found to be participating in payment practices deemed in violation of the Medicare statute could face criminal prosecution and expulsion from Medicare and all state health care programs, including Medicaid.

In comments responding to the proposed safe harbor regulations, the AMA criticized the proposals, calling them too restrictive. According to the AMA, the regulations could impede delivery of necessary medical care to Medicare and Medicaid patients.

Each safe harbor is restricted by a long list of conditions that individuals and entities must follow for their payment practices to be covered. Physicians should consult the *Federal Register* for a complete listing of the conditions accompanying each proposed safe harbor. The new proposed safe harbors address these areas:

- Provision of medical malpractice insurance subsidies to physicians and nurse midwives by hospitals and other entities. At least 85 percent of practitioners' patients must reside in a government-designated primary health professional shortage area.
- Physician recruitment agreements. To be covered, hospitals or other entities must recruit physicians who are attempting to attain staff privileges and have been practicing in their current specialty for less than a year or who are relocating their main practice to the areas served by

the recruiting facilities.

- Referral arrangements for specialty care. Referrals are protected only when patients are referred to physicians who have the skill to provide care that referring physicians are unable to give.
- Back-and-forth payments between Cooperative Hospital Services Organizations owned by two or more tax-exempt hospitals and their patron hospitals. These payments must be for specific services such as purchasing, billing or clinical services, and payments are protected only when the services solely benefit the patron hospitals.

The proposed rule also includes three additions to the existing investment interest safe harbor. The expansions are limited by several conditions and cover the following:

- Physician investments in rural areas. According to a condition of this safe harbor, at least 85 percent of the entity's revenue must be collected from rural residents.
- Surgeon ownership of ambulatory surgical centers. Investing surgeons must perform surgery on patients they refer to the center. The centers must be certified and maintain their own operating and recovery room space.
- Physician investment in group practices. The group must be owned exclusively by the physicians investing in the group.

For more information about government regulations, physicians may contact ISMS' health care finance division at (312) 782-1654, ext. 1131, or (800) 782-ISMS. ■

Medicare officials will not question payment practices that meet the requirements of a safe harbor.

practices will remain immune from government scrutiny, the proposed regulations are very narrowly defined, according to ISMS analysts. Physicians are encouraged to consult their personal attorneys to discuss their individual circumstances.

Currently, those additional safe harbors are just a proposed rule; however, ISMS advisers warned that with minor modifications, these proposals will probably become final regulations. At that time, payment practices not specifically covered by one of the 13 current or four

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Illinois Medicine

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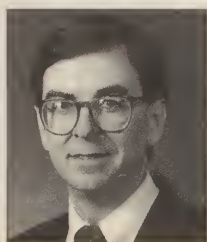
When cost
containment
cuts into
patient care

PAGE 10

AMA parameters forum stresses physician input

EDUCATIONAL TOOL: The AMA works to ensure the scientific and clinical relevance of nationally developed guidelines. By Gina Kimmey

[CHICAGO] Like ISMS, the American Medical Association is concerned about the recent imposition of mandatory practice guidelines in a managed care network by Blue Cross and Blue Shield of Illinois, said John T. Kelly, MD, director of the AMA's office of quality assurance. "We have concerns in Illinois because it is unclear how BCBSI developed these particular practice parameters, how they plan to use them and what their expectations of physicians are. There are many questions that are unresolved that certainly we



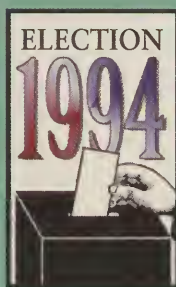
Dr. Kelly

hoped would be clarified before they were implemented." The AMA advocates practice parameters primarily as an educational tool, he added.

Practice guidelines are nothing new. In the past decade, health care providers have been inundated with practice parameters aimed at helping screen, diagnose, treat and follow up with patients. In fact, the number of established practice parameters has more than doubled in just the last five years, according to the AMA.

In 1989, the AMA recognized
(Continued on page 15)

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Candidates discuss health care issues

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ISMS BEHIND THE SCENES

HELPING PHYSICIANS PREPARE FOR THE FUTURE

ISMS is launching a far-reaching health system reform initiative to meet the changing needs of Illinois physicians. The new plan is part of the Society's ongoing campaign, Health Reform: Taking Charge of Change.

According to ISMS President Arthur R. Traugott, MD, this multifaceted program is aimed at helping physicians navigate their way through the evolving health care marketplace. The plan is detailed in the ISMS brochure "Looking to Your Future," which was recently mailed to all Illinois physicians, Dr. Traugott said. Among the new projects approved by the board of trustees at its Jan. 22 meeting are the establishment of a wide range of new services, the potential development of an ISMS physician managed care network, a stepped-up Washington Presence program and a public education program.

"Physicians are under increasing pressure from business and insurers to control costs and join integrated health care systems," said Dr. Traugott. "As the framework of the health care delivery system changes, so, too, do physicians' practice needs. I agree with Einstein, who said, 'The significant problems we face cannot be solved with the same level

of thinking we used when we created them.'"

Dr. Traugott noted that the program is designed to provide physicians with the necessary tools to make critical decisions about their practices. The Society will help doctors set up physician organizations and provide tax, accounting and legal services.

A feasibility study regarding an ISMS-developed physician network is also under way, Dr. Traugott said. Several managed care options will be studied, including an independent practice association, a preferred provider organization, a health maintenance organization and the "clinic without walls" approach.

ISMS will also build on the success of its Washington Presence program by intensifying its focus on antitrust and tort reform, Dr. Traugott noted. The Society's expanded legislative strategy includes visits to Capitol Hill and meetings with the Illinois congressional delegation, he added.

"Antitrust reforms are essential. Physicians must be allowed to compete on a level playing field to ensure that quality of care doesn't suffer in the name of cost containment.

(Continued on page 14)

Republican bill offers consumer choice

REFORM: A new bill in Congress would give tax credits to individuals to purchase health insurance. By Anna Chapman

[WASHINGTON] A recently introduced health system reform bill is garnering heavy support from House and Senate Republicans. Twenty-four Republican senators co-sponsored the Consumer Choice Health Security Act, S. 1743, introduced by U.S. Sens. Don Nickles (R-Okla.), Orrin Hatch (R-Utah) and Connie Mack (R-Fla.). A similar House bill, H.R. 3698, introduced by U.S. Rep. Cliff Stearns (R-Fla.), currently has 20 co-sponsors, including Illinois Reps. Henry Hyde (R-Addison), J. Dennis Hastert (R-Batavia) and Philip Crane (R-Arlington Heights).

The plan offers more consumer choice than the Clinton plan, said Lestor Munson, Hyde's press secretary. It is based on a model developed by the Heritage Foundation, a nonpartisan public policy research and education institute. Under the plan, patients could not be denied coverage

because of pre-existing conditions, and insurance companies could not raise premiums because of a policyholder's health status. Premiums would be based solely on the policyholder's age, gender and geographic characteristics, according to a *Heritage Issue Bulletin* devoted to the legislation.

Unlike the Clinton bill, the Nickles-Stearns package would not raise taxes, create large regulatory bureaucracies or impose mandates on employers to provide and pay for health insurance plans for their employees, Heritage said. Instead, the plan would provide universal coverage through a system of tax credits.

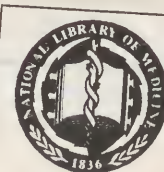
"The bill gives the individual more of a say economically," Munson explained. "It's a bill that will address specific problems. It does a much better job than the Clinton plan in reducing cost."

(Continued on page 8)



John McNulty

JOHN YOUNG (LEFT) AND PETER WHITTINGTON, MD, celebrate during the University of Chicago Hospitals' eighth annual reunion for liver transplant patients in December. John, now 2½, received a new liver when he was eight weeks old.



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Funding critical for poison centers

PREVENTION: Poison control efforts are in jeopardy. By Gina Kimmey

[PEORIA] Physicians attending a Dec. 3 meeting of the Illinois College of Emergency Physicians discussed ways to prevent the state's two remaining poison control centers from closing. During the past 10 years, lack of public funding forced poison control centers to close in Peoria, Pekin and Springfield. Now, only Rush-Presbyterian-St. Luke's Medical Center in Chicago and SwedishAmerican Hospital in Rockford are operating poison control centers in Illinois.

"It is very difficult to run a nonrevenue-producing part of the hospital with no outside funding," said Sam Gaines, MD, of St. John's Hospital, which operated the Springfield center. The poison control center handled more than 30,000 calls and cost the hospital \$340,000 annually, Dr. Gaines explained. Last year, when hospital administrators started cutting costs, the poison control center was eliminated. It closed Sept. 1.

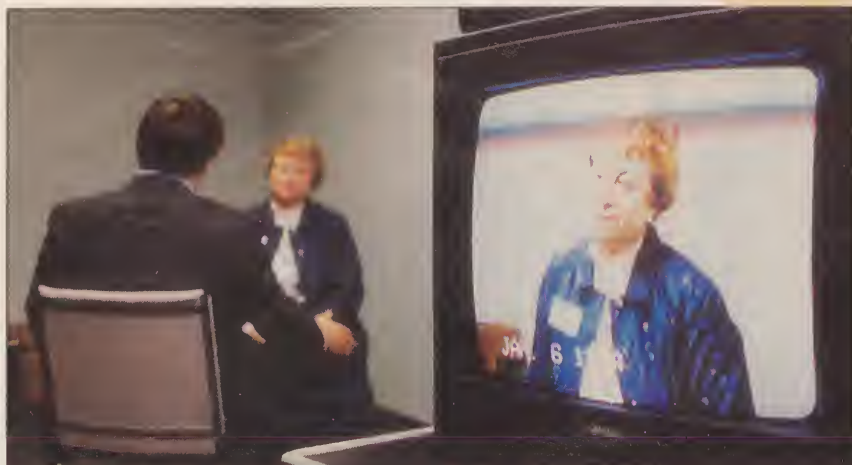
Since then, SwedishAmerican has taken the calls that would have gone to St. John's. SwedishAmerican has avoided additional staff costs by training nurses to answer the poison control center's phones, said Nancy Oldenberg, clinical manager for the Rockford center. But calls to the center have jumped from about 800 per month a year ago to about 2,400 a month, Oldenberg said.

"We are keeping up, but it's hard," she said. "We have had to curtail our educational outreach programs, because all of our nurses are staffing the poison control center. Without funding, our future is uncertain."

According to Dr. Gaines, a bill was introduced in the legislature last year that called for adding a 10-cent charge to each household phone bill to help pay for the state's poison control centers. But the bill did not emerge from committee, said Leslie Stein-Spencer, chief of the Illinois Department of Public Health's division of emergency medical services. IDPH is hoping to support poison control centers using general revenue funds next year, she said. If such funding is appropriated, the department will try to reopen the St. John's center, she noted. "IDPH is very supportive and committed to keeping poison control centers operating. It is a great source of concern that access to poison control by the public would be diminished."

"This should not be just a hospital concern, but a public concern," said Jerrold B. Leikin, MD, medical director of the Rush poison control center, which handles an average of 120 calls per day. The center's staff prevents 15,000 unnecessary emergency room visits each year, Dr. Leikin said. State funding for the two remaining centers is essential to ensure that poison control services remain available in Illinois, he added.

"Optimally, we would like to see funding available so that St. John's could reopen," Oldenberg said. "We operate better when we can serve our immediate area, provide more outreach and community activities and educate people on prevention. That's really what poison control is all about."



CLAIR M. CALLAN, MD, of Lake Forest, learns how to answer reporters' questions effectively during a Jan. 6 spokesperson training session. The program is part of ISMS' Health Reform: Taking Charge of Change campaign.

MADD rates Illinois No. 1

[SPRINGFIELD] Illinois' fight against drunken driving has been the most successful in the nation, according to a survey released by Mothers Against Drunk Driving and the Advocates for Highway and Auto Safety. The organizations' 1993 "Rating the states" survey gave Illinois an A- grade for its efforts to decrease drunken driving. The national average was B-.

States were rated in 11 areas, including gubernatorial leadership, statistics and records, enforcement, administrative and criminal sanctions, prevention and public awareness, and legislation. According to MADD, Illinois' high marks stemmed in part from the state's 30-percent decrease in highway deaths during the '80s, its system of maintaining drunken-driving-offense information on drivers' license records and its progressive penalties for subsequent offenders.

"Over the past 12 years, Illinois has made dramatic progress in the fight against drunken driving," said Gov. Jim Edgar. "We have gone from having one of the worst laws in the country to having the most effective program in the nation to deter and combat drunken drivers. Most importantly, thousands of lives have been saved and countless injuries prevented due to this effort."

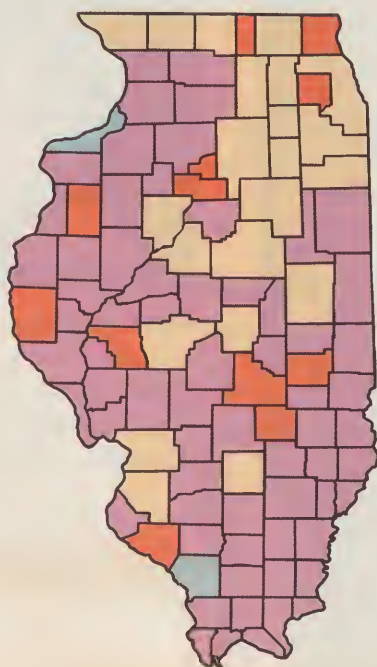
"The people of Illinois deserve this recognition for all their hard work to fight the epidemic of drunken driving," Edgar added. "This rating is an indication of the progress that citizens, government and private industry can make by working together."

Although MADD Illinois is encouraged by Illinois' rating, executive director Gary Kenzer said there is more work to be done "as long as there are needless deaths and injuries caused by drunken drivers on our highways."

PHYSICIAN FACTS

Illinois' distribution of primary care physicians

Counties or parts of counties qualify as federally designated physician shortage areas if their population numbers more than 2,400 residents per primary care doctor. For Illinois Department of Public Health data collection purposes, primary care includes general and family practice, general internal medicine, Ob/Gyn and pediatrics.



- Entire counties designated as primary care shortage areas
- Counties with specific service area physician shortages
- Counties with physician shortages for a certain population group
- Counties with no physician shortage

Source: Illinois Department of Public Health, Center for Rural Health, December 1993

Accidental deaths down, Safety Council study says

[ITASCA] The accidental death toll in the United States for 1992 reached its lowest point in 70 years, the National Safety Council reported. In 1992, 83,000 people died accidentally, compared with 76,000 accidental deaths in 1922, according to the NSC report.

In its annual statistics compilation, *Accident Facts*, the council noted that as the population increases, accidental deaths are decreasing. "Considering that the nation's population in 1922 was about 110 million and rose to more than 255 million in 1992, the overall accidental death total of 83,000 recorded [in 1992] is a remarkable achievement in accident prevention," said Alan Hoskin, manager of the council's statistics department.

"There has been a tremendous amount of research into injury prevention," said John R. Lumpkin, MD, director of the Illinois Department of Public Health. Dr. Lumpkin said he prefers using the term "injury" rather than "accident," because most "accidents" can be predicted and prevented. Research has shown that such precautions as the use of motorcycle helmets, bicycle helmets, air bags, car seats, structural designs on equipment and changes in behavior have aided in injury prevention, he said. The Illinois death rate from injuries other than violent injuries has always been lower than the national average, he added.

The council uses four categories for statistical reporting: motor vehicle accidents, work-related accidents, accidents in the home and accidents in public places, said Anne Callen, an NSC statistician. In 1992, work-related deaths and accidental home deaths hit the lowest levels ever recorded — 8,500 and 19,500 respectively. The 19,500 figure for home deaths represents a 7-percent decrease from 1991, when the total was 21,000 deaths, NSC said.

Motor vehicle-related deaths in 1992 were at their lowest level since 1961, when there were 61-percent fewer vehicles on the road, according to the NSC. There were 40,300 motor vehicle deaths in 1992, compared with 38,100 in 1961.

Only deaths from accidents in public places increased, from 17,000 deaths in 1991 to 18,000 deaths in 1992.

The 1992 NSC statistics are based on 1990 death certificate data collected by the National Center for Health Statistics, a division of the U.S. Public Health Service. Accidents cost Americans \$399 billion in 1992, according to NSC estimates. Medical expenses for all accidents were estimated at \$75.2 billion. ■

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Candidates discuss health care issues

ANALYSIS: Primary campaigns for state government officials are in high gear. By Gina Kimmey



[CHICAGO] Illinois voters will head to the polls March 15 to elect Republican and Democratic nominees for statewide offices. Many of the candidates con-

tacted by *Illinois Medicine* for this report are familiar to Illinois physicians, since they are currently serving in other capacities in state government. What follows is a rundown of the primary candidates for secretary of state, attorney general, treasurer and comptroller.

Secretary of state

Running unopposed in the primary, Republican incumbent George H. Ryan has been a leading advocate for traffic safety issues during his first term as secretary of state. He has introduced significant initiatives to reduce drunken driving and co-sponsored a statewide designated-driver program. Late last year, Ryan announced that during the spring General Assembly session, he will reintroduce legislation to reduce the minimum acceptable blood-alcohol content for drivers from .1 percent to .08 percent. Ryan also implemented the "Operation Precious Cargo" program to encourage the use of child safety seats by making them available at all Illinois drivers' license exam stations.

In the general election, Ryan will face one of two Democratic challengers — state Sen. Denny Jacobs (D-Moline) or Illinois Treasurer Patrick Quinn. Quinn also favors reducing the legal blood-alcohol limit to .08. In addition, he supports "not a drop" laws, which mandate drivers' license revocation for teenagers convicted of driving under the influence. Quinn said he believes the secretary of state should be a "forceful consumer advocate" for Illinois drivers, particularly in the insurance arena. He added that if elected, he would achieve annual budget reductions in the secretary of state's office, just as he has done in the treasurer's office.

According to Jacobs, the key to getting drunken drivers off the road is dealing effectively with repeat DUI offenders, not lowering blood-alcohol limits. As secretary of state, he would focus on enacting stricter penalties for second- and third-time offenders. Jacobs said he supports issuing restricted drivers' permits for first-time offenders, increasing DUI education efforts and making treatment for alcoholism more widely available.

Attorney general

In the race for Republican nomination for attorney general, DuPage County State's Attorney Jim Ryan is battling Jeff Ladd, a partner at the Chicago law firm Bell, Boyd & Lloyd. Both candidates have identified violent crime as the No. 1 issue in this campaign.

In particular, Ryan named the fight against gangs and drugs as his top priority. He said that if he is elected attorney general, he will continue to protect the rights of battered women and children. He noted that in DuPage County he has initiated a treatment program for abuse

victims and established the state's first child advocacy program.

Ladd said he will introduce legislation to shorten the lengthy appeals process for death row inmates. He also promises to coordinate the crime-fighting efforts of all Illinois' state's attorneys.

In addition, Ladd said he supports a

cap on noneconomic damages, but did not name an amount. Ryan said he believes there is a need for tort reform in Illinois and noted that he will release specific positions later in the campaign.

Vying for the Democratic nomination are Chicago attorneys Albert Hofeld and Martin J. Oberman. If elected attorney general, Oberman said he would work to increase funding for public education and monitor the spread of legalized gambling to limit corruption. He promised to introduce a bill that would allow the state to collect a higher percentage of casino profits. Currently, Illinois collects only 20 percent of gambling profits. Oberman said his proposal would yield

\$440 million in revenue for Illinois. The money could be used to fund hospital and nursing home Medicaid reimbursements, he said. Regarding tort reform, Oberman said he opposes a cap on noneconomic damages in medical malpractice cases.

A former president of the Illinois Trial Lawyers Association, Hofeld said he has 30 years of experience fighting for the "little guy" against special interests, such as the medical establishment, the pharmaceutical industry and insurance interests. He is a member of the Inner Circle of Advocates, a national organization of civil trial attorneys.

(Continued on page 14)

Blue Cross Blue Shield



REPORT

FOR Illinois Physicians

"PRACTICE GUIDELINES" - ONE EXAMPLE

In the "Blue Sheet" of a recent edition of *Illinois Medicine*, Blue Cross Blue Shield of Illinois (BCBSI) described in some detail its initiative in setting forth Practice Guidelines. BCBSI urges you to again read that article. Some of the major points of that previous "Blue Sheet" were the following:

- ◆ Practice Guidelines have been developed by prestigious medical organizations, including specialty colleges.
- ◆ BCBSI has not developed Practice Guidelines by itself, but rather has promulgated the Practice Guidelines proposed by outstanding professional colleges and agencies, and/or has worked with leading specialists to develop Guidelines.
- ◆ The Practice Guidelines are not immutable, but will be regularly reviewed and possibly revised as a result of consultation with outstanding specialists in the applicable specialties.

In this issue of the "Blue Sheet", BCBSI is printing in its entirety one of the Guidelines that it set forth. This is being done so that members of the Illinois State Medical Society can see that the Guidelines were developed by the medical profession itself and that they are consistent with high quality medical practice. This Guideline pertains to Elective Red Blood Cell Transfusion. This particular Guideline is a summary of an article written by the American College of Physicians; the reference is printed at the bottom of the Guideline, as it was when this Guideline was inserted into the Provider Manual for Physicians in BCBSI's Managed Care Network Preferred (MCNP).

POLICY ON STRATEGIES FOR ELECTIVE RED BLOOD CELL TRANSFUSION

The purpose of this policy is to promote the appropriate selection of cases and application of technique in elective red blood cell transfusion.

- (1) Elective red blood cell transfusion may be indicated in patients whose level of anemia is sufficient to cause symptoms related to RBC loss, after correction of hypovolemia or medical treatment of the anemia with iron, B12, folate, or erythropoietin as appropriate. Normovolemic anemias with hemoglobin as low as 7 g/dl can be well tolerated in asymptomatic patients. Prophylactic transfusion, and transfusion to enhance general sense of well-being or to expand vascular volume when oxygen-carrying capacity is adequate, are not indicated. The previous practice of routine transfusion for hemoglobin <10g/dl irrespective of symptoms and signs is no longer valid. Volume expanders should be used initially, where appropriate, in peri-operative cases.
- (2) When transfusion is indicated, blood should be administered on a unit-by-unit basis, with evaluation of the need for additional transfusion after each unit.
- (3) Where the need for transfusion is anticipated, planning to ensure availability of autologous blood is indicated if medically appropriate.

Reference: American College of Physicians, Practice Strategies for Elective Red Blood Cell Transfusion, AIM 1992;116(5):403-406.

(Issue: 01/28/94 - ALW)

Congressional primaries



Several upcoming congressional primary races are of interest to organized medicine. In the 2nd and 5th Congressional districts, incumbent Reps. Mel Reynolds (D-Chicago) and Dan Rostenkowski (D-Chicago) face primary challenges. Rostenkowski is chairman of the House Ways and Means Committee, which has jurisdiction over health care legislation.

Reynolds is a freshman member of that committee. Rep. J. Dennis Hastert (R-Batavia), who represents the 14th Congressional District, is also being challenged in the primary. Hastert was the Republican representative on the White House reform task force and serves on the House Energy and Commerce Committee, which also considers reform legislation. The following is a brief look at the health reform positions of candidates in the 8th, 11th and 18th district races.

YOCON® YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

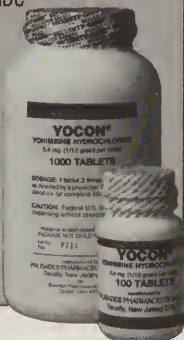
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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8th district

Philip M. Crane (R)

System I recommend: Private sector-free market system

Funding sources I support: Tax credits for insurance premiums and contributions to tax-free medical savings accounts. Federal spending should be reduced to offset the cost of the credits.

Clinton plan: Oppose

Other plans supported: I am a co-sponsor of H.R. 3080, the House Republican leader's health reform bill, and H.R. 3698, which is based on a reform model developed by the Heritage Foundation.

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: As tax credits for insurance premiums and medical savings accounts benefit our country by making health insurance more affordable and containing costs, they will also benefit each of us in Illinois. By linking health care funds to individuals rather than specific jobs, this approach will provide Illinoisans with the freedom to change jobs without losing their health coverage.

Peter G. Fitzgerald (R)

System I recommend: Private insurance plans made portable and immune from cancellation, tax credits for low-income individuals and medical savings accounts

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: None

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Medicaid reform that prevents individuals from dumping assets and impoverishing themselves to become eligible for nursing home benefits

Donald Huff (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, sin taxes and patient payments via medical IRAs

Clinton plan: Oppose

Other plans supported: None will be passed in current form

\$250,000 cap on noneconomic damages: Favor, if tied to the level of negligence rather than the pithy of a jury

Other reform suggestions: Provider "report cards" to monitor quality and reduced paperwork bureaucracy

Gary Skoien (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: None

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: We must allow market forces to work by educating consumers about health care products and foster the creation of careful health care shoppers so that hospitals and doctors charge competitive prices for quality services.

Judy McCracken Svenson (R)

System I recommend: The present system with reform

Funding sources I support: Income taxes by increasing pretax dollars to pay

insurance premiums, sin taxes

Clinton plan: Oppose

Other plans supported: Cooper-Chafee plan, with modifications

\$250,000 cap on noneconomic damages: Favor, but not necessarily \$250,000

Other reform suggestions: Risk should be spread so that everyone can receive coverage. Pretax dollars should be used to cover premiums.

Michael Strelka (D)

System I recommend: Public-private partnership

Funding sources I support: Employer mandates, combination of government funding and employer-paid benefits, taxes on health care services and higher registration fees for firearm owners

Clinton plan: Support, with changes

\$250,000 cap on noneconomic damages: Favor a \$500,000 cap

Other reform suggestions: Reforming Medicaid to prevent fraud and abuse, streamlining claims-processing system, and reducing unnecessary surgery and diagnostic fees, especially those resulting from treatment at physician-owned diagnostic facilities

Robert C. Walberg (D)

System I recommend: Single payer

Funding sources I support: Payroll taxes and sin taxes

Clinton plan: Oppose

Other plans supported: Single payer

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: In reforming the current health care system, we must provide cost containment, universal coverage, freedom of choice, quality and equity to ensure that everyone contributes based on his or her ability to pay.

11th district

Robert T. Herbolzheimer (R)

System I recommend: Private-public partnership

Funding sources I support: Combination of government funding and employer-paid benefits and cuts in government spending

Clinton plan: Oppose

Other plans supported: House Republican plan and U.S. Rep. J. Dennis Hastert's Medisave plan

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: National policies are needed to replace fragmented state programs. Numerous changes are also needed to eliminate high administrative costs, but creating a huge federal bureaucracy is not the answer.

Gerald R. Kinney (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding, employer-paid benefits and individual contributions

Clinton plan: Oppose

Other plans supported: Comprehensive Family Health Access and Savings Act

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: Audit insurance companies to determine whether losses are truly due to excessive verdicts or some other investment decision and consider further reforms depending on results. Improved cost and waste control on Medicaid and Medicare, and relaxed antitrust rules.

James J. O'Connell (R)**System I recommend:** Tax-free medical saving accounts**Funding sources I support:** Tax-deductible employer plans, high-deductible insurance plans and tax-free medical savings accounts**Clinton plan:** Oppose**Other plans supported:** Patient medical savings accounts**\$250,000 cap on noneconomic damages:** Favor**Other reform suggestions:** Switching from low deductibles to high deductibles to lower employer premiums, permitting Americans to claim tax benefits for purchasing catastrophic health insurance**Sam Panayotovich (R)****System I recommend:** Public-private partnership**Funding sources I support:** Combination of government funding and employer-paid benefits**Clinton plan:** Oppose**Other plans supported:** House Republican plan**\$250,000 cap on noneconomic damages:** Favor, but with a sliding scale that takes into account the amount of negligence and the severity and permanency of the resulting injury**Other reform suggestions:** Specifics of the House Republican plan**Jerry Weller (R)****System I recommend:** Cooperation between government and the private sector**Funding sources I support:** Administrative savings, an increase in the federal retirement age from 55 to 62, and a phase-out of federal Medicare subsidies for senior citizens with incomes of more than \$100,000 a year**Clinton plan:** Oppose**Other plans supported:** Affordable Health Care Act sponsored by U.S. Rep. Bob Michel**\$250,000 cap on noneconomic damages:** Favor**Other reform suggestions:** My legislation, H.B. 1, will be considered this year by the General Assembly. It calls for reducing regulatory burdens for cooperative purchasing of health insurance by small businesses and extending a 100-percent tax deduction to the self-employed and small employers who employ between two and 50 people. Improved tort reform and new tax breaks for physicians who provide charity care would improve access and reduce costs.**Bill Barrett (D)****System I recommend:** Public-private partnership**Funding sources I support:** Combination of government funding and employer-paid benefits; sin taxes on the sale and transfer of firearms and ammunition; and contributions for people who are working, similar to Social Security funding**Clinton plan:** Oppose**Other plans supported:** Points of the Cooper-Grandy plan**\$250,000 cap on noneconomic damages:** Favor caps, but not necessarily \$250,000**Other reform suggestions:** Let's get a handle on Medicaid costs while improving access, look to the insurance industry and providers to work with small businesses to address their needs and make better use of existing resources.**John "Jack" Buchanan (D)****System I recommend:** Public-private partnership**Funding sources I support:** Combination of government funding and employer-paid benefits, sin taxes**Clinton plan:** Oppose**Other plans supported:** I hope I am given the opportunity in Congress to help define the plan I will support.**\$250,000 cap on noneconomic damages:** Oppose**Other reform suggestions:** Uniform control of insurance paperwork to help decrease administrative costs, pharmaceutical industry reform**Frank Giglio (D)****System I recommend:** Public-private partnership**Funding sources I support:** Combination of government funding and employer-paid benefits**Clinton plan:** Support, with some changes**\$250,000 cap on noneconomic damages:** Oppose**Other reform suggestions:** Education should be geared toward encouraging more students to become general practitioners. Steps should be taken to provide better access for rural residents.**David W. Neal (D)****System I recommend:** Public-private partnership**Funding sources I support:** Combination of government funding and employer-

paid benefits

Clinton plan: Support**\$250,000 cap on noneconomic damages:** Oppose**Other reform suggestions:** We have the finest doctors and health care professionals in the world, yet we have a Medicaid system and a health care system that do not work. The Medicaid system's cost is not reflected in the quality of care some individuals receive. Individuals who defraud this system must be punished. Physicians and other health care professionals must be included in the reform process.

(Continued on page 12)

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BRIEF SUMMARY
Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.
Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.
Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

Naming names

Why does *Illinois Medicine* publish disciplines? There is no easy answer to that question. The policy has been reviewed at least once a year, usually in response to queries from physicians who have been disciplined by the Illinois Department of Professional Regulation, the state agency that provides this newspaper with the information we reprint. To the doctor who has confronted the disciplinary process, publication of his or her name in *Illinois Medicine*, of all places, seems like adding insult to injury. How can *Illinois Medicine* justify publishing these names?

We do it in the name of the big picture. We do it in the interest of physician self-regulation and peer review. And ultimately we do it because every time we ask the question, the answer is, "Because it's the right thing to do, that's why."

Because we, as professionals, must take a strong and public stand on the right and responsibility of medicine to police and discipline physicians.

ISMS supports a sound investigative and disciplinary function, with physicians actively involved in the entire process. That's an important enough point to reiterate: Disciplinary questions are asked by and disciplinary measures are recommended by physicians in IDPR. In the IDPR process, doctors are reviewed, judged and disciplined by physicians working within the framework of state law and working alongside state officials

whose responsibility is to enforce state law.

The Society supports that process and even lobbied to raise licensure fees to provide the revenue to increase those efforts several years ago.

No less a critic of medicine than Sidney Wolfe of the Ralph Nader organization Citizen Action in Washington had to grudgingly give credit to the medical profession in Illinois for the profession's – and the Society's – role in policing itself and supporting state disciplinary activities.

But it's not enough to say we do it because if we don't, Sidney Wolfe will. We do it because we believe in and support the concepts of physician peer review and state – not federal – regulation of medicine.

We print the information exactly as it is received from IDPR. We do not, for example, omit the names of those doctors who are disciplined because they were late in renewing their licenses.

If we did, the next step would be to exclude the names of doctors who commit some other "minor" infraction – and it's a slippery slope from there on.

So we publish disciplines because it's the right thing to do. To not do so would be to open the door, just a crack, to other self-declared experts who would like to take over the medical review and discipline process.

More important, we publish disciplines because professionalism – guarding the high standards of medical care – is our most important asset.

PRESIDENT'S LETTER

Unifying behind a common goal

By Arthur R. Traugott, MD



It would be tragic to merely substitute our current system with one that gives government carte blanche to impose costly bureaucracy.

In mid-December, President Clinton hosted a meeting with representatives of a number of medical specialty societies to reinforce the administration's demand for employer-mandated universal health care coverage. Participating societies included the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians and the American Society of Internal Medicine.

The American Medical Association was not asked to attend the meeting. It's important to keep in mind that the AMA's policies and positions are developed through the democratic process – from the bottom up, not the top down. Issues are debated extensively by the House of Delegates, then concerns are carefully presented to the president and the public. As an association representing grass-roots physicians throughout the country, the AMA should be included in national reform discussions and meetings.

In response to President Clinton's meeting, I sent the following letter to meeting attendees:

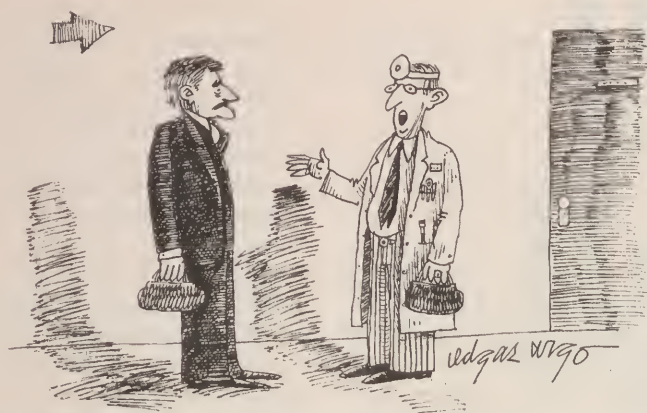
On behalf of the Illinois State Medical Society's 18,000 physician members, I am asking your organization to reconsider your apparent blanket endorsement of President Clinton's health reform plan. In our view, your presence at the president's news conference sent a divisive and unfortunate message to physicians nationwide. While ISMS applauds President Clinton for having brought forth a serious debate on health reform, we strongly believe our profession cannot afford to ignore the many substantive shortfalls of the administration's plan. Perhaps the most serious of these is the positioning of federal policy-makers as central arbiters of medical quality, medical services availability, insurance coverage and issues regarding medical costs and funding mechanisms.

I would respectfully request that your society, on behalf of the many physicians you represent, remain unified with all of medicine, including the American Medical Association, in order to achieve the best reform plan possible. There is no question that health reform is essential; it would, however, be tragic to merely substitute our current system with one that gives government carte blanche to further intrude and impose costly bureaucracy upon the physician-patient relationship. The many intractable problems of Medicare and Medicaid give us reason to doubt the wisdom of such a move.

I hope you would also agree that physicians should be truly involved in the process and implementation of health reform. To date, the president and his advisers have not broadly offered our profession a substantive role; nor have they solicited, on a broad-based level, our practical advice and counsel, recognizing that we have actual expertise in patient care and management. In fact, the president's plan was purposefully developed without broad-based medical input.

While acknowledging that each specialty organization (including my own) has a priority agenda for the many health reform issues now under debate, we at ISMS sincerely believe that only by "sticking together" can we and our patients "win" in the end. Let us not reprise the debacle of RBRVS, when the splintering of medicine resulted in an inferior final product. If the AMA is effectively "cut out" from reform, we all stand rebuffed. If the politics of exclusion prevail, reform cannot, in our view, succeed.

Assuring that all Americans have access to health care is too important to be distracted by specialty society differences. If medicine cannot unify behind this common goal and our patients' health care is compromised, we all lose.



"People don't bother me with their problems at parties anymore. ...
I started asking them for urine samples."

LETTERS

Discipline update

Among the disciplines provided by the Illinois Department of Professional Regulation and published by *Illinois Medicine* last year was a discipline in which I was named. According to the notice, my physician and surgeon licenses were "indefinitely suspended after failing to disclose a felony conviction from a sister state and for suffering from a mental illness." I appealed this decision.

On Sept. 8, the Circuit Court of Cook County reversed IDPR's March 22 finding that I suffer from a mental illness and am unable to practice medicine. On Nov. 22, the Circuit Court of Cook County also reversed IDPR's finding that I was convicted of a felony in California. Also on Nov. 22, IDPR moved to stay the circuit court's order pending appeal. IDPR's motion was denied. As a result of the reversals and of that denial, the National Practitioner Data Bank has expunged my file, and I am free to practice medicine.

— Lawrence S. Krain, MD
Chicago

Editor's note: IDPR is appealing the decision of the Circuit Court of Cook County in Dr. Krain's case. Illinois Medicine's editorial policy is to publish verbatim IDPR reports regarding physician disciplines. The newspaper exercises no editorial control over the content of these reports and publishes disciplines as space is available. Physicians may update the status of their cases by submitting letters to the editor.

Affordability claims don't hold water

The ideas expressed in U.S. Rep. J. Dennis Hastert's guest editorial "The Republican approach to affordable health care," published in the Dec. 17, 1993, issue of *Illinois Medicine*, are a valuable contribution to the goal of uninterrupted health care security for all. Such a promise is implied in his bill, the Affordable Health Care Now Act of 1993, currently being considered in Congress.

However, the claim of affordability, though enticing, is utterly unacceptable. Lifetime security cannot depend on the nation's ability to bear costs without serious inconvenience.

Indeed, an insured's ability to afford health insurance rests on variable factors, such as the ability to work, uninterrupted employment, assured income and stable expenses. Affordability may also change for insurers; they are currently permitted to decrease coverage when costs become too burdensome. Reduced coverage could be fatal for individuals who are chronically or critically ill, and it could be catastrophic in the event of a severe epidemic or other natural disaster. The insurance industry is dependent on so many factors that it cannot guarantee security if policyholders are temporarily or permanently unable to afford premiums. Therefore, regardless of how people obtain their insurance, the promise of lifetime security cannot rely on the insurance industry.

Lifetime security, regardless of ability to pay, can be guaranteed only by a governmental agency — a single payer with a single policy covering all residents, like Social Security, Medicare or Medicaid. Financing would have to be derived from income and other general taxes. This is how we finance the agencies that provide us with national defense and local police, fire fighting and public health protection. It is also how we currently pay for the health care of 38 million uninsured.

An increase in tax rates will never be popular, yet it is feasible now if it is properly introduced and explained. The U.S. General Accounting Office reported in June 1991 that total health care costs under a single-payer system would be less than is spent now. Additionally, a recent CBS and *New York Times* poll found that 61 percent of Americans are willing to accept a tax increase to secure lifetime health care.

The people are ready. The president's goal should not be delayed. Meanwhile let's abrogate the word affordable from any plan that promises a lifetime of uninterrupted security.

— Paul Ravenna, MD
Evanston

If you have an opinion on a story published in Illinois Medicine, please share it with other readers. Send your letter to Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. We reserve the right to edit letters for space and style.

GUEST EDITORIAL

A perspective on education

By Tien C. Cheng, MD

Today's physicians face enormous pressures. Patients demand the best care, good results, unlimited access and no risks. People are also questioning the effectiveness of the nation's health care system. The health industry, third-party payers and the government want universal care at lower cost.

To help physicians cope with the changing realities of modern medicine, we must begin to address the deficiencies in medical education.

The current medical education system is not meeting the country's needs and must be altered under health system reform. Medical education curriculum should be changed to prepare doctors for the changing environment in which they deliver care. Specifically, physicians must receive better training in medical ethics, personal relations, human psychology and behavior, communication, computers, law and cost-effectiveness.

Most internal medicine programs require only three years of training even though the American Society of Internal Medicine has recommended a fourth year of training since 1982. This fourth year is necessary to convey the enormous amount of information internists need to know, as well as to provide the trainees with professional visibility and confidence in their specialty.

In addition, since ambulatory care and managed care are being propelled by third-party payers and the health insurance industry, curricula must be altered to help physicians deal with the growing emphasis on these types of service delivery. To meet those demands, there should be more integration of training programs in community hospitals and private office practices. This will expand learning, as well as ensure that trainees are exposed to the spontaneity of real-life situations. Becoming knowledgeable about medicine without clinical experience can make a person a good educator, but not a good clinician.

Current medical training programs may not adequately prepare generalist physicians for practice, which is part of the reason they are losing ground to subspecialists. During training, internists and family physicians are learning less and less about more and more, in contrast to subspecialists, who are learning more and more about less and less. Primary care physicians continue to lose professional visibility when they must refer patients to subspecialists to undergo a relatively simple test, such as a stress test,

an EEG, a pleural aspiration or a sigmoidoscopy. In those cases, primary care physicians must sit back and wait for specialists to provide them with information about their patients. Administrators of internal medicine programs must decide which procedures their residents should master and then ensure that the trainees receive the necessary training and testing for competency, formal certification or mastery of each procedure.

Given the rising elderly population in the United States, training programs for generalist physicians should be modified to place more emphasis on managing chronic illnesses. Curricula should also be based on medical practice guidelines. These guidelines have been compiled by many subspecialty organizations, as well as the government.

The importance of certification and recertification in training programs must also be considered. For better or worse, certification recognizes that physicians have completed qualified training programs. Certification provides across-the-board standards that assure the health industry, the government and patients that physicians are medically competent in their specialty.

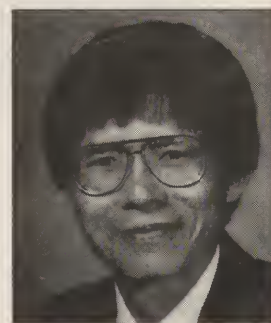
Many diseases, such as AIDS, Legionnaires' disease and chronic fatigue syndrome, were not completely understood or did not exist 10 to 15 years ago. Therefore, it is critical to incorporate the flood of information about new diseases into medical school and training curricula. Some states are already mandating changes in medical education. For example, Florida now requires AIDS education for all physicians, and Texas mandates family practice rotations in medical school. Medical educators must take the lead and implement the necessary modifications in medical school and training program curricula before legislative mandates like those enacted in Florida and Texas become more commonplace.

Physicians should also become more sensitive and compassionate about the financial burdens of their patients. By reviewing bills for services rendered by consultants and hospital-based doctors who also treat their patients, physicians in training can learn to select more cost-effective services from the wide array of services available, while providing the highest quality of care.

Physicians should also learn to recognize the need for a multiple disciplinary approach to patient care. Doctors must be able to coordinate the health care team and learn the appropriate circumstances for using the skills of paramedical personnel. In addition, training should emphasize when and why generalist physicians should refer patients to medical or surgical subspecialists.

As a cardiologist, I am a subspecialist. In this capacity, I try to see my patients as a generalist would. I look at each patient as a whole person, not as a single organ system. I read, listen, think, and I seek

consultation. I discuss treatment recommendations directly with my patients when possible and brief family members about patients' conditions. Like all my colleagues, I am faced with increasing pressures regarding ethical, moral and economical issues. The future is sure to bring additional pressure as well. But if medical education is properly reformed, our future physicians will be ready to conquer whatever comes.



Dr. Cheng is a board-certified cardiologist in Gurnee.

Republican bill

(Continued from page 1)

For physicians, the bill would provide liability and antitrust reform. Its liability reform provisions include limiting noneconomic damages in medical malpractice suits to \$250,000, modifying the statute of limitations for filing malpractice claims and making defendants liable for the amount of noneconomic or punitive damages for which they are responsible. The plan would also limit attorneys' fees to 25 percent of the first \$150,000 of awards and settlements and 15 percent of the amount above \$150,000.

The bill also includes antitrust reforms

that would create safe harbors for groups of providers, medical not-for-profit self-regulatory entities, joint ventures for high technology and services, and hospital mergers in certain instances, Heritage said. Also included are additional safe harbors for health care joint ventures formed to increase access, improve quality of care and achieve cost efficiencies. In addition, the bill enables some providers to obtain certificates exempting them from antitrust laws for activities related to providing health care services.

The plan would be funded by the elimination of tax exclusions for employers who purchase group health benefits for

their employees. It places responsibility for purchasing health insurance on individuals, according to Heritage. Under the plan, employers would pay their workers the value of their current health plan as earned wages. Employees would then use those funds to purchase coverage through their employer or through a group, such as a church or a professional organization, Heritage said. All heads of households would be required to purchase basic catastrophic health insurance that covers themselves and their family members.

Instead of providing companies with tax exclusions for sponsoring health plans, the government would give individuals tax credits beginning Jan. 1, 1997.

The credits would be awarded on a sliding scale based on health care expenses relative to income, according to the plan. Standard tax credits would be 25 percent of the cost of insurance premiums and out-of-pocket expenses. The percentage would increase for households with lower incomes, depending on the percentage of income spent on health care.

To illustrate how much people will earn in tax credits, Heritage provided the following example. A family with an annual income of \$30,000 may have health care expenditures of \$4,000. Under the plan, households would receive a 25-percent tax credit on the amount they spent on health care, up to 10 percent of their annual income, which in this case is \$3,000. The remaining \$1,000 of the family's health care expenses falls between 10 percent and 20 percent of its annual income. The tax credit for that portion of expenses would be 50 percent. Therefore, the family's total tax credit would be \$1,250 - \$750 for the first \$3,000 of expenses plus \$500 for the remaining \$1,000 of health expenses. Expenses that make up more than 20 percent of a household's income would be credited at 75 percent of those costs.

Individuals may also choose to contribute to medical savings accounts, according to the plan. Those funds could be used for out-of-pocket medical expenses, including insurance premiums, Heritage said. The plan would limit annual contributions to \$3,000, plus \$500 for each dependent. Individuals would receive a 25-percent tax credit on medical savings account contributions.

Further funding mechanisms would also be necessary, since tax credits under the plan would be higher than the current tax deductions and exclusions they would replace, according to a fact sheet on the plan issued by Stearns' office. The plan would also require Medicare and Medicaid cuts totaling \$139 billion over five years. But benefits would not be reduced, a Stearns district newsletter stated. Savings would be achieved by converting hospitals' Medicaid disproportionate share payments into state grants for care delivered to the needy, as well as allotted tax credits. ■

Adolescent abuse cases increase, JAMA reports

[CHICAGO] Child abuse among teen-agers is on the rise, according to a report published last fall in the *Journal of the American Medical Association*. Prepared by the AMA's Council on Scientific Affairs, the article quotes figures from the "Annual Fifty State Survey" conducted by the National Committee for the Prevention of Child Abuse.

According to the article, "Adolescents as Victims of Family Violence," 208,000 cases of abuse involving adolescents between 12 and 17 years old were reported in 1990. This total accounts for 25 percent of child abuse cases reported to protective service agencies that year. In 1991, more than 2.5 million cases of child abuse were reported, and a substantial number of those cases involved adolescents.

Recent surveys show that reported child abuse occurs at a rate of 42 cases per 1,000 children. All surveys using official reports showed an increase in the number of abuse cases between 1980 and 1991, the JAMA article said. ■



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ISMIE Update

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caps*

PAGE 3

GUEST EDITORIAL

Fact vs. fiction: The truth about malpractice costs

By Harold L. Jensen, MD

A Dec. 11 meeting of the Metropolitan Chicago Chapter of the American College of Surgeons featured a debate between two Illinois legislators about the merits of professional liability reform. Many physicians may have heard about the criticisms that Rep. Louis Lang (D-Chicago) leveled at the Exchange and tort reform during his debate with Sen. Kirk Dillard (R-Hinsdale). It's important for physicians to know that many of Lang's allegations about ISMIE and the lack of need for tort reform are simply not true.

Dillard was able to respond to many of Lang's comments during the debate, but I believe it is critical to provide the facts regarding malpractice costs, which may have been misconstrued by Lang. While you con-

sider the evidence countering Lang's remarks, bear in mind that Lang is a well-known advocate of the Illinois Trial Lawyers Association. He serves as chairman of the House Judiciary I Committee and is a leading opponent of tort reform. Lang was instrumental in the defeat last year of an ISMS-supported bill calling for a \$250,000 cap on noneconomic damages in civil cases. Although the bill had cleared the Senate, it was killed on a do-not-pass motion in Lang's House Judiciary Committee.

Lang contended that ISMIE has paid all losses using only a portion of its investment income. In reality, the Exchange is operating at a loss ratio of 135 percent for the 1993-94 policy year. In other words, the company's paid and unpaid

losses are 35 percent higher than what policyholders were charged in premiums. ISMIE must use investment income to cover the balance. Lang also failed to consider that the Exchange is required by state law to maintain its reserves — the funds set aside to pay losses each policy year — at a certain level. In fact, the state audits ISMIE every three years to confirm its financial stability.

Lang also questioned ISMIE's current premium rates, stating that the number of medical malpractice cases in Illinois has decreased. It is true that in 1986, after the enactment of a number of professional liability reforms, the frequency of malpractice cases declined. Since then, however, the frequency of claims has steadily increased.

The representative also failed

to consider the increasing severity of claims — a crucial factor in the rate-setting equation. In 1985, ISMIE paid an average of \$105,000 on malpractice claims. In 1993, that number had spiraled to \$345,000.

Regarding the success of tort reforms in stabilizing liability-related costs, Lang said premium and other health care costs have not decreased in states that have already enacted caps. Statistics on premium rates in those states, however, do not support Lang's claim. Instead, they show that premiums have stabilized and, in some instances, have been reduced. In California, for example, malpractice premiums for physicians increased only 5.2 percent from 1981 to 1988. Colorado also placed a \$250,000 cap on noneconomic damages. In 1992, physicians in that state paid premiums that were 20 percent lower than what they had paid four years earlier.

Caps will also reduce the indirect costs associated with medical malpractice litigation. By decreasing the threat of malpractice suits, physicians will feel less constrained to practice defensive medicine. Doctors will be able to order tests solely on the basis of

whether they are appropriate and necessary, instead of for liability protection.

Finally, Lang alleged that medical malpractice insurance premiums make up only 1 percent to 2 percent of physicians' gross income. But I know of many physicians in high-risk specialties who pay premiums as high as \$70,000 a year and who would take strong issue with the representative's numbers. In fact, a recent AMA study showed that malpractice premiums constitute 9 percent of physicians' total office costs.

Lang did encourage physicians in attendance at the meeting to call ISMIE with questions and concerns about these issues. On this single point I agree. As a company owned and managed by physicians, ISMIE is dedicated to providing exemplary service to its policyholders. Physicians who have questions about this situation or any liability insurance matter are encouraged to call the Exchange at (312) 782-1654 or (800) 782-ISMS. ■

Dr. Jensen is chairman of the Exchange board of governors.

MALPRACTICE ROUNDUP

Physician not liable for office staff error

A Texas court ruled that a physician was liable for the actions of his office staff in his absence. A patient filed suit against the physician, claiming she sustained injuries because the office staff failed to direct her to another physician when the defendant physician was out of the office. According to the *Medical Liability Advisory Service*, the patient claimed the physician was responsible for a communication breakdown between her and his office staff. The jury found the physician and his office staff equally liable, but an appeals court reversed the decision, stating that the plaintiff failed to show evidence of the physician's negligence. ■

Insurers fear increased liability in Clinton reforms

According to *National Underwriter*, insurers attending the Professional Liability Underwriting Society's 1993 international conference in Houston last November expressed concern that President Clinton's health system reform plan could increase liability exposure for medical providers. Insurers said the proposed health security cards could create new liability concerns related to record keeping. Medical providers will probably be responsible for updating patients' medical histories on the cards. Failure to update the card and ensure that the information is accurate could lead to malpractice claims, insurance company representatives contended.

Increased liability could also result from the pressure to control costs within health care entities formed by physicians, hospitals and managed care organiza-

tions, insurers said. Cost containment will lead to conflicts between business and medical priorities, they predicted. In addition, one insurer noted that it is easier for patients to sue a "faceless corporation than an individual physician." ■

Mammography not a diagnostic tool

As the number of women diagnosed with breast cancer rises, so does the incidence of breast cancer litigation, according to *Physicians Quarterly*, a publication of MMI Companies Inc., a firm that provides professional liability insurance and risk management consultation. According to the company, mammography should be used to screen for cancers that cannot be diagnosed by physical examination. Using mammography to evaluate breast lumps that are already discernible by touch is inappropriate, MMI said.

In claims of failure to diagnose breast cancer, physician orders for mammograms after the detection of palpable breast masses often lead to judgments for plaintiffs, MMI warned. That is because when mammogram results are negative, physicians typically tell their patients to return in six months to monitor their condition, the company said. However, the false-negative rate of mammography is 10 percent to 15 percent. Therefore, definitive diagnostic tests, such as surgical biopsy, not mammograms, should be used for diagnosing breast lumps. Ordering and documenting the proper diagnostic tests can make breast cancer malpractice suits easier to defend, according to MMI. ■

MANAGED CARE

When cost containment cuts into patient care

The financial concerns of HMOs are becoming a sword of Damocles dangling over the heads of physicians – and their patients.

BY RICK PASZKIET

T

he primary goal of physicians is to act in their patients' best interests. But HMOs and other managed care plans have another main goal: holding down costs. Sometimes, in the course of providing care, these aims clash, and the results can be tragic.

A multimillion-dollar lawsuit filed in Downstate Illinois illustrates the dangers patients face when their physicians' treatment recommendations are not supported by a managed care plan's policy. In November 1993, St. Clair County Associate Judge James Radcliffe found Prudential Health Care Plan Inc. (Prucare) liable for the wrongful deaths in 1989 of Mary Coley and her unborn son, Kenneth Coley II, and for the pain and suffering she endured before her death. Prucare and the Coley estate agreed on a settlement just prior to a jury trial that had been scheduled to assess damages.

The Coley suit was one of the first cases in Illinois to examine physician-HMO relationships and the pressure HMOs can exert on physicians, said Tom Ducey, a Belleville attorney who represented the Coley estate. "This was the first time in Illinois that an insurance company was found liable for the way it manages health care. Currently, there are about 18 cases pending in Illinois that focus on the management decisions of HMOs."

Coley was a bond trader for A.G. Edwards and received medical coverage from Prucare as part of her employee benefits package. In May 1989, she was admitted to St. Elizabeth's Hospital in Belleville 38 weeks into her pregnancy.

"Her diagnosis was toxemia pregnancy," Ducey said. "Since she was only two weeks short of full term, the normal course of treatment would have been to put her on a fetal monitor, stabilize her condition and then deliver the baby by cesarean section when the physician deemed Mary and the baby were safe."

Ducey said Prucare instructed Coley's physician to

discharge her four days after she was admitted to the hospital. The physician, however, wanted to keep her in the hospital a few more days to monitor her condition and then follow the standard treatment for toxemia pregnancy, he added.

The physician's recommended treatment could not be carried out, though. Physicians who contract to accept Prucare patients are required to follow the HMO's "Utilization Management Manual and Physicians Office Guide," Ducey explained. This "contract" requires a physician to receive Prucare's authorization for medical procedures and related therapies. Under the terms of the agreement, Prucare retains the right to approve or deny patients' admission to a hospital and decide when patients should be discharged.

"Ten days after her discharge, on Mother's Day, she collapsed and was taken back to St. Elizabeth's by ambulance," Ducey said. "Her son was delivered still-born by cesarean section that same day. Mary's condition rapidly deteriorated. Her kidneys and liver failed, and she had more than 12 blood transfusions. She finally died six weeks later, after being transferred to the high-risk pregnancy center at Jewish Hospital in St. Louis."

THE COLEY CASE depicts the consequences of situations in which HMOs, instead of physicians, make critical patient care decisions, Ducey said. The lawsuit poses the question, Who has the right to determine the type of health care patients receive?

"With Mary Coley and Prucare, we saw the downside of managed medical care," Ducey said. "The HMO tells the doctor what he or she can or cannot do, but the HMO bureaucrat doesn't have the experience or specific case knowledge to make such formidable decisions. This case re-emphasizes the point that doctors should be permitted to practice medicine to the best of their ability, with little interference from HMO bureaucrats. Quite simply, HMOs

MANAGED CARE



Larry Limnitis

should not tell doctors how to practice medicine.”

Kevin Heine, director of public relations for Prudential, said the insurer is unable to discuss certain aspects of the case because of a confidentiality agreement signed by Prucare and the Coley estate as part of the settlement. “Neither side was allowed to present final arguments,” Heine said. “The judge’s ruling was based on technical grounds, not on the merits of the case. If the facts were presented, they would show that Prucare was not responsible for the medical decisions made.”

NO MATTER WHO is to blame for the Coley deaths, the case fuels the ongoing debate about the level of influence HMOs exert over physicians.

“Although an HMO doesn’t demand that physicians relinquish their rights in deciding what’s best for the patient, there is incredible pressure put on the physician to follow the HMO’s standards and requirements,” said Ronald G. Welch, MD, a neurologist from Belleville and ISMS Tenth District trustee. “HMOs wield enormous power, especially for the physician whose practice depends on HMO patients.”

According to U.S. Commerce Department reports, HMO enrollment between 1987 and 1992 rose from 29.3 million to 41.4 million. However, during that same period, the number of HMO networks actually declined from 662 to 544. This translates into fewer but larger – and perhaps more influential – HMOs.

Dr. Welch said economics is becoming a sword of

Damocles dangled over physicians by managed health plans. The pressure to contain costs places physicians in a precarious situation: They must either go along with the HMO or risk losing the HMO contract – and, possibly, their livelihoods.

“It’s a medical necessity for the physician to be in charge of a patient’s care,” said Dr. Welch. “An HMO wants physicians to follow its own rules and orders. The result is a chilling effect between managed health plans and physicians, which can result in poor patient care.”

Physicians are more concerned with patient care than cutting costs, Dr. Welch said. “With managed medical plans, there is a tendency to disregard the patient for cost savings. What begins to occur is that the HMO starts second-guessing the doctor when it comes to selecting treatments that are seen as being too expensive. The physician becomes hamstrung, and the patient ultimately suffers.”

Dr. Welch added that the Coley case demonstrates the need to find a middle ground between HMOs’ concern for cost savings and physicians’ responsibility to provide their patients with the highest-quality care. “As more emphasis is being put on managed competition and more health care plans coalesce, there will be even greater pressure put on the physician to follow the terms of the HMO. However, physicians have no choice but to be advocates for giving patients the best possible care in spite of any pressure from third parties.” ■

Congressional primaries

(Continued from page 5)

Marty Gleason (D)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, but no further debt should be incurred to fund health care

Clinton plan: No preference stated

Other plans supported: None

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: This matter will change considerably in the coming months. Compromise is inevitable.

18th district

Dennis Higgins (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: Affordable Health Care Act

\$250,000 cap on noneconomic damages: I favor heavy restrictions on malpractice awards, however, I am not sure where the dollar amount should be placed.

Other reform suggestions: Look at reforms adopted by other states like Indiana, which has provided the lowest malpractice premiums in the nation and provides more dollars for injured patients. I also

advocate placing a cap of 15 percent or less on lawyers' fees and a more competitive market for insurance premiums and health care costs.

Ray LaHood (R)

System I recommend: Using the private free market system with some government assistance and direction

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: A plan that reduces costs, increases access, maintains quality, provides choice, preserves jobs, enhances flexibility for states and localities, ensures fair tax treatment of health care purchasers, encourages individual responsibility, is fiscally responsible and focuses reform efforts on proven strategies, not bureaucratic designs

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Insurance reform that limits premium fluctuations and ensures portability; employee access to affordable insurance through employers; eased group insurance purchasing by employers; reduced costs through malpractice reforms, paperwork simplification, and antitrust and Medicaid reform

Judy Koehler (R)

System I recommend: Public-private partnership

Funding sources I support: Before committing to additional taxes or government

mandates, we should explore ways to cut costs and more efficiently direct health care spending.

Clinton plan: Oppose

Other plans supported: Before committing to any plan, I suggest Congress enact most, if not all, of the reforms I have mentioned.

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Make insurance premiums for the self-insured tax deductible, streamline administrative paperwork and ensure the working poor of access via a voucher or tax credit program. Whenever possible, the federal government should let state governments work on problems such as the Medicaid burden.

Thomas J. Homer (D)

System I recommend: Government-controlled single payer

Funding sources I support: Combination of government funding and employer-paid benefits and savings from streamlining the insurance industry

Clinton plan: Support, with changes

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: The system must allow patients and their provider, not insurance companies, to determine appropriate medical services. Illinois must overhaul its Medicaid program to ensure adequate and dependable funding. Payment delays, coupled with reduced reimbursement rates, have caused financial uncertainties and hardships for providers.

Timothy J. Howard (D)

System I recommend: Public-private partnership

Funding sources I support: Employer mandates, sin taxes and premiums paid by individuals

Clinton plan: Oppose

Other plans supported: Cooper-Grandy

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: The Cooper plan would abolish and replace Medicaid. Access to health insurance would be guaranteed. Basic benefits would emphasize preventive care and require all participants to contribute to their care.

G. Douglas Stephens (D)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, as well as trimming government and private inefficiencies

Clinton plan: Support some parts, but oppose others

Other plans supported: The final solution will be a hybrid between a plan in which businesses are required to provide coverage for their employees or contribute to a federal fund and national health care.

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: The ultimate issue is whether lawmakers will listen to the ideas and needs of the medical community and devote the needed resources to adopt reasonable reforms that do not diminish the current high quality of care. ■

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Helping physicians

(Continued from page 1)

Additionally, ISMS will continue to work cooperatively with the AMA to achieve broader tort reforms. Enacting caps on noneconomic damages is critical if physicians are to gain the peace of mind necessary to reduce the practice of defensive medicine."

The Society has also implemented an aggressive public education campaign, Dr. Traugott said. The campaign includes town meetings sponsored by ISMS and county medical societies throughout the state to provide a forum for exchanging information about

reform. The forums are free and open to the public.

The first town meeting was held Jan. 26 in Chicago, and the second is slated for Feb. 3 in Springfield. Two more town meetings have now been scheduled for Feb. 10 in Rockford and Feb. 16 in Carterville. Johanna Lund, president of the Rockford Council for Affordable Health Care, will moderate the Feb. 10 meeting at the University of Illinois College of Medicine at Rockford Auditorium. Panelists will be Sen. Dave Syverson (R-Rockford); William E. Kobler, MD, ISMS 12th District trustee; Dave Lindsay, vice chairman of Employer's Coalition on Health; Dennis Culloton, senior govern-

ment relations specialist for Blue Cross and Blue Shield of Illinois; Jerry Nash, PhD, CEO of St. Anthony Medical Center; and Jodi Muselin, anchorperson at WREX-TV, Channel 13.

The Feb. 16 meeting will be held in the Crisp Room at John A. Logan College in Carterville. The program will be moderated by Terry Caldwell, an anchorperson for ABC affiliate WSIL-TV. Panelists are U.S. Rep. Glenn Poshard (D-Marion); William F. Hays, MD, a member of the Williamson County Medical Society; Jack J. Buckley Jr., CEO of Southern Illinois Healthcare Enterprises and Subsidiaries; and Kenneth Dawes, a district executive board member of the United

Mine Workers of America.

ISMS is also providing regional spokesperson training seminars to prepare physicians for public speaking engagements and media interviews, Dr. Traugott said. In addition, the Society is developing patient information kits about reform, to be distributed in physicians' offices, he added. "These are confusing times for many, and we want physicians to be prepared to answer questions from their patients and the public concerning health system reform."

Dr. Traugott stressed that physician input is crucial to the success of the ISMS reform strategy. Society representatives will soon travel throughout the state to meet with physicians, hospital medical staffs and county medical societies to gather information about physicians' current and future needs, he said.

"We need your input. It's that simple. Take a moment to call the Society or complete the response card included in the mailing. As the AMA's Dr. James Todd has said, 'Health care reform is not a spectator sport.'"

For more information about ISMS' reform efforts, call (800) 782-ISMS. ■

Find out more about health care reform in Illinois —
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Town Meetings and Discussions on Health Reform

Rockford

Thursday, February 10
University of Illinois College of Medicine
at Rockford Auditorium
1601 Parkview Ave.
Rockford, IL
7 p.m.- 8:30 p.m.

Moderator

Johanna Lund

President, Rockford Council for Affordable Health Care

Panelists

Sen. Dave Syverson
(R-Rockford), Illinois State Senate

William E. Kobler, M.D.
District Trustee, Illinois State Medical Society

Dave Lindsay
Vice Chairman, Employer's Coalition on Health

Jodi Muselin
Anchorperson, WREX-TV, Channel 13

Jerry Nash, Ph.D.
CEO, St. Anthony Medical Center

Dennis Culloton
Senior Government Relations Specialist
Blue Cross and Blue Shield of Illinois



Marion

Wednesday, February 16
John A. Logan College, The Crisp Room
Green Briar Road
Carterville, IL
7 p.m.- 8:30 p.m.

Moderator

Terry Caldwell

News anchor, WSIL-TV (ABC)

Panelists

Rep. Glenn Poshard
(D-Illinois), U.S. House of Representatives

William F. Hays, M.D.
Member, Williamson County Medical Society

Jack J. Buckley Jr.
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Candidates

(Continued from page 3)

Treasurer

State Sen. Judy Baar Topinka (R-North Riverside) is running unopposed in the race for the Republican nomination for state treasurer. Topinka is currently serving her third term in the Senate and is chairman of the Public Health and Welfare Committee. During her tenure in the Senate, Topinka has sponsored many health-related bills and has been an ardent supporter of physicians' issues.

According to her campaign materials, she supports legislation to eliminate government waste, pay bills more promptly and institute generally accepted accounting principles for state government. As treasurer, she would establish a committee of financial advisers selected from the public and private sectors, her press package states.

Democrat Nancy Drew Sheehan did not respond to requests for comment.

Comptroller

Loleta A. Didrickson, director of the Illinois Department of Employment Security, is running unopposed in the Republican primary for state comptroller. Didrickson said that during her four terms as a state representative, she was one of the first lawmakers to sponsor mandatory mammography screening legislation and one of the initial sponsors of ISMS-backed legislation endorsing a \$250,000 cap on noneconomic damages in medical malpractice cases. If elected, Didrickson said she is committed to forging an improved working relationship with the General Assembly to expand total quality management in the comptroller's office, including paying state bills more efficiently.

Candidates for the Democratic nomination include state Sen. Earlean Collins (D-Chicago) and Kane County Coroner Mary Lou Kearns, RN. Kearns said she proposes establishing a "rainy day fund" to build cash reserves for the state. In addition, she said she will appoint a balanced-budget commission to provide revenue estimates for a balanced budget each fiscal year.

Collins could not be reached for comment. ■

AMA forum

(Continued from page 1)

a need to ensure quality in the development, evaluation and implementation of those parameters. So the association assembled representatives from more than 80 medical specialty and state medical societies and formed the Practice Parameters Forum. "The particular issue that led to the creation of the forum was a recognition of the benefits of coordinating all of the various organizations that were actively developing parameters, as well as those that would be using them," said Dr. Kelly.

ISMS House of Delegates policy directs the Society to participate in the AMA's parameters forum and recognizes that when properly developed by physicians, practice parameters may promote quality care.

When it initially published the *Directory of Practice Parameters* in 1989, the AMA listed 700 practice parameters, Dr. Kelly noted. This year's directory identifies 1,500 practice parameters developed

take into account certain local factors," he noted. These factors include patient case mix, availability of resources and relevant scientific and clinical information.

The steps for implementation state that after particular parameters have been chosen, physicians should be able to evaluate the extent to which their practices conform to the recommendations, whether their practices should be modified in some way or whether their patients are sufficiently unusual that certain recommendations don't apply.

"Our very strong view is that the physicians who are going to be using the practice parameters or whose practices are going to be affected by them have to

be actively involved in decisions regarding which practice parameters are to be used," said Dr. Kelly. "It is essential that the physicians who are expected to use these practice parameters be involved in decisions regarding their selection, their evaluation and their adoption, as well as decisions about how they are going to be used."

Physicians have also raised questions regarding the professional liability implications of following practice parameters. According to Dr. Kelly, certain states have attempted to link practice parameters with professional liability relief. For example, in return for agreeing to follow practice parameters, physicians may

receive liability protection in case of an adverse event. There may be risks for physicians who are expected to follow certain practice parameters and then are not provided with some level of liability protection, he added.

"What we have to be very careful about is putting physicians in a double-bind situation, where they are strongly encouraged to follow particular recommendations, but if an adverse event occurs, they are held liable," said Dr. Kelly. "We think there needs to be considerable attention to the professional liability implications of any effort to promote the implementation of practice parameters." ■

*Practice parameters are
an aid to clinical
decision making, not a
replacement for
physician judgment or
experience.*

by more than 45 physician organizations. As the number of those recommendations increased, the forum developed five principles to help ensure "scientifically sound and clinically relevant practice parameters," Dr. Kelly said.

The principles state that parameters should be developed by or with the cooperation of physician organizations; should be based on reliable methodologies that integrate relevant research findings and clinical expertise; should be as precise and comprehensive as possible; should be based on current information and updated every three years; and should be widely disseminated in peer-reviewed and other widely circulated publications.

"Practice parameters developed following these principles can provide a very useful foundation for physicians in making certain clinical decisions," Dr. Kelly said. "It's important to remember, however, that practice parameters are an aid to clinical decision making, not a replacement for physician judgment or experience. They provide recommendations that a physician should review and then decide how best they apply to his or her particular patients."

In addition to providing guidelines for practice parameter development, the forum recently published an 11-step guide to aid implementation of parameters at local, state and regional levels. The guide provides a structured approach that physicians and organizations can use in reviewing practice parameters and choosing the most appropriate ones, according to Dr. Kelly.

"We see the practice parameters as a starting point for physicians in certain decisions but recognize that no matter how good national recommendations might be, they need to be modified to

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Illinois Medicine

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Edgar endorses tort reform, expanded access

STATE OF THE STATE: The governor urges Illinois to move on health system reform. By Anna Chapman

[SPRINGFIELD] Gov. Jim Edgar's strong call for tort reform drew loud applause from the floor of the Illinois General Assembly during his Jan. 12 State of the State address. Edgar said the current tort system produces too many lawsuits and explained that excessive litigation raises health care costs, the cost of doing business in Illinois and local taxes. To remedy this situation, he promised to introduce legislation during the upcoming General Assembly session to reform medical malpractice and product liability laws.



Edgar

"Once again, I renew my call to bring sanity to a tort liability system that generates far too many lawsuits and far too much money for a few millionaire lawyers who milk it," Edgar said. "Those victimized by the

neglect of others should be compensated. But the victims can and should be compensated without needlessly driving up costs for businesses, boosting health care costs and other prices for consumers, and without raising taxes for taxpayers."

During his mostly upbeat speech, Edgar described the state's success in holding the line on taxes during the recent economic downturn. Illinois is on more solid ground economically than it was a year ago, he said. "We have adopted a fiscal discipline that requires the state to live within its means and stop spending money it doesn't have."

Edgar also cited the need for expanded health care access for Illinoisans, an overhauling of the state workers' compensation system and a statewide ban

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CHICAGO MEDICAL SOCIETY President Sandra F. Olson, MD (left), ISMS President-elect Alan M. Roman, MD (center), and Ray Werntz, a business representative, answer questions during the Jan. 26 town hall meeting on reform sponsored by ISMS and CMS.

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Federal agency issues new practice parameter for HIV

GUIDELINES: The AHCPR develops recommendations with physician input. By Anna Chapman

[WASHINGTON] The U.S. Public Health Service's Agency for Health Care Policy and Research released a new HIV clinical practice parameter Jan. 20 to help primary care physicians provide critically important care to those recently infected with the virus, according to the agency. The guideline addresses disclosure, patient evaluation, monitoring and management, and will pave the way for future guidelines on other aspects of HIV care, the agency said.

The HIV guideline includes recommendations for treatment of women, adolescents and children, the agency said, noting that women and adolescents represent the fastest-growing population groups to contract HIV. Two accompanying consumer brochures, which target HIV-infected adults and caregivers of HIV-infected children, urge readers to learn all they can about HIV and work with

their physicians.

The agency plans to release parameters on benign prostatic hyperplasia this month and cancer in March, said J. Jarrett Clinton, MD, AHCPR administrator. Dr. Clinton was appointed to his post under the Bush administration and will be replaced this spring by Clifton Gaus, a senior adviser to the head of the Public Health Service. Dr. Clinton will remain with the PHS in another capacity.

Congress created the agency in 1989 and charged it with facilitating the private-sector development of clinical practice parameters. The AHCPR guidelines are not standards but recommendations based on clinical panels' intense research of peer-reviewed medical literature, Dr. Clinton explained. For each guideline, there is one panel — a multidisciplinary group that includes specialists, generalists, nurses, allied health profession-

(Continued on page 12)

Suburban AIDS program issues call for primary care physicians

INDIGENT CARE: As HIV infection increases in suburban Cook County, so does the need for treating physicians. By Anna Chapman

[OAK PARK] A two-year-old project aimed at providing primary care for indigent HIV-infected patients in suburban Cook County is running short on a vital resource: physicians.

Administered by the Cook County Department of Public Health, the Suburban HIV Care Project is funded by the federal government through the Ryan White CARE Act. The program's goals include preventing hospital stays, prolonging patients' lives and improving the quality of their lives, said the department's HIV coordinator Joan Gordon, RN. Those goals can be accomplished by giving patients access to early intervention at the primary care level, she said.

The need for physician participants is increasing, because the number of AIDS cases in the suburbs is rising, Gordon said. During the first six months of 1993, suburban AIDS cases increased 52 percent over the same period in 1992, according to CCDPH statistics.

The northern and western suburbs are fairly well-staffed with physicians, but patients in the southern and southwestern communities are severely underserved, Gordon said. The department believes it is unreasonable to ask patients who live in the rural southern suburbs to travel 40 miles to receive care, she said.

HIV- or AIDS-infected patients participating in the program are not eligible for Medi-

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Migraines are more than just another headache

TREATMENT: Awareness of causes and available treatments can ease the pain of migraine sufferers. By Gina Kimmey

[CHICAGO] A patient complains of nausea, severe head pain and sensitivity to light, sound, movement and smell. It's all in the patient's head, according to Hilliard E. Slavick, MD, assistant professor of clinical neurology at Northwestern University Medical School. He or she is most likely suffering from a migraine headache. But advances in the understanding and treatment of migraines have made it unnecessary for patients to endure endless suffering from those headaches, Dr. Slavick told reporters during a December briefing.

"For years, [migraine patients] were told it was nothing serious — just stress, tension, anxiety or sinus pressure," said Dr. Slavick. "But that's no longer acceptable, because we have treatments and tips to help patients overcome this disease. This is an extremely debilitating disease and one that requires a physician who is up-to-date with its treatment and management and can intercede in the disease cycle to get the patient back to functioning in his or her activities of daily living."

Migraines occur when cerebral blood vessels dilate too much, allowing an excess of blood into a particular area of the brain, he explained. Researchers believe the neurotransmitter serotonin plays a significant role in migraines, although its role is not clearly understood, Dr. Slavick said. Patients excrete high levels of serotonin during migraine attacks, he added.

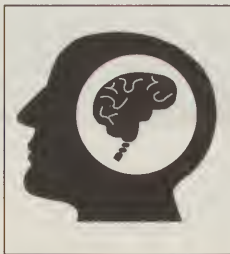
Patients typically experience moderate to severe pain usually on one side of the head. The pain may last from four hours to three or four days. According to Dr. Slavick, migraines often are undiagnosed or confused with other headache conditions, such as cluster or tension headaches. The pain associated with tension or muscle-contraction headaches is usually described as a pressing or tightening and is less severe than migraine pain. Cluster headaches are identified by intense pain on one side of the head, accompanied by eye tearing, stuffy nose and facial flushing, but they usually last for only 30 to 45 minutes. They can occur many times a day for two or three weeks at a time.

More than 11.3 million Americans suffer moderate to severe disability from migraine headaches, said Dr. Slavick. Women are three times more likely to be affected than men. Migraines are most common in patients between 35 and 45 years of age, but they typically begin in the teen-age years, around the time of menstruation.

"Migraines take an enormous toll in terms of personal suffering by the patient and also in disruption of families' lives," Dr. Slavick said. "Suddenly their body is controlling them, and there is nothing they can physically do to prevent it or to deal with it in that moment, in that situation."

According to Dr. Slavick, the corner-

stones for effective treatment are drug therapy and identifying the triggers that cause migraines. Recognizing an individual's triggers is the most cost-effective treatment and one the patient can easily control, he said. Triggers range from hormonal changes to diet, and can include emotional stress, changes in sleep or eating patterns, alcohol and some medications. He advises his patients to keep a diary of their headaches, including when they start, how long they last and which specific factors may have triggered them. He also tells patients to grade headaches on a scale of one to 10.



Medical therapy can be administered in one of two ways, Dr. Slavick said. Daily prophylactic therapy helps reduce the number of attacks for patients suffering migraines two or three times per month. This therapy can include beta-blockers, which help prevent blood vessels from swelling. The other approach is acute therapy, including analgesics or nonsteroidal anti-inflammatory medications to treat symptoms during an attack.

"The myth is that people must suffer through their migraines, but there is no reason for this anymore," said Dr. Slavick. The key is for physicians to differentiate between the types of headaches, because treatment and therapy are different for each one, he added. ■

Edgar announces anti-violence program

[BENSENVILLE] Gov. Jim Edgar unveiled additions to the Drug Abuse Resistance Education program Nov. 17 in Bensenville. The expanded program will focus on helping children resist street gangs and the crime associated with them.

"Too many of our children today face overwhelming obstacles in their path to growing up and becoming successful and productive members of society," Edgar said. "The scourge of drugs, gangs and guns threatens the very lives of kids today."

The Illinois State Police developed the anti-violence material for DARE. Twenty local police department DARE officers completed training to administer the program in local schools, officials said.

"The battle against street gangs has to be fought wherever encountered, and

unfortunately, sometimes that's in the school," said State Police Director Terrence W. Gainer. "We believe that we can have a strong, positive influence on kids, and we are pleased that so many communities are willing to get involved to fight the spread of street gangs."

Edgar announced the DARE expansion at Mohawk School, one of 33 new sites for Project Success, a children's initiative he launched in 1992. Project Success coordinates school-based social services to address children's problems in a familiar setting, according to the governor's office. Project Success and DARE are designed to tackle the problems children face each day, Edgar said.

"Enforcement alone will not rid us of gangs," said DuPage County State's Attorney Jim Ryan, who helped develop the DARE curriculum. "For every hard-core gang member, there are a thousand children at risk. That's why prevention programs like DARE are so important." ■

State enacts 18-month Medicaid rate freeze

[SPRINGFIELD] Last month, Gov. Jim Edgar's administration announced an 18-month freeze on Medicaid reimbursement rates for nursing homes and hospitals. The rate freeze, effective Jan. 1, is expected to save about \$145 million in Medicaid payments to nursing homes and \$135 million in hospital payments, according to the governor's office. The freeze does not affect physicians' reimbursement rates.

"We view this as a way that we can initiate our efforts to contain Medicaid costs with as little disruption as possible to health care providers," said James R. Reilly, Edgar's chief of staff.

The administration agreed to the freeze after nursing homes and hospitals balked at an earlier proposal to cut

reimbursement rates by 9.7 percent. The action is aimed at keeping Medicaid costs within budget appropriations.

"Illinois, like other states in the nation, has been grappling with soaring Medicaid costs that will continue to play havoc with state budgets unless we rein them in," said Reilly. "Obviously, the industry, the legislature and our administration are faced with tough negotiations and decisions in the months ahead. We stand ready to cooperate. All of us, though, must realize that the state must live within its means and can't spend money it doesn't have." ■

IRHA annual meeting set for March

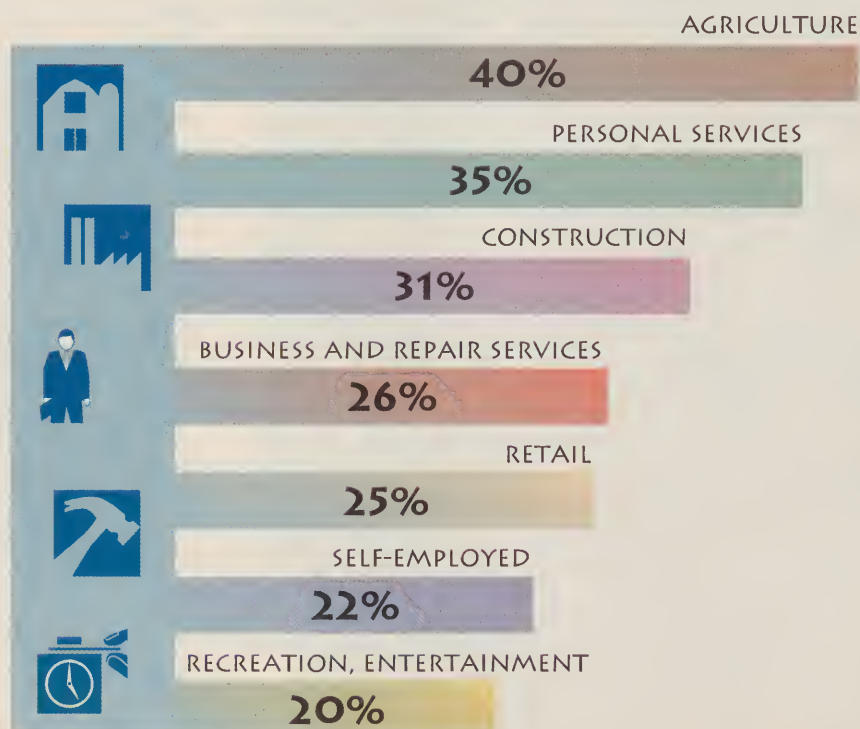
[URBANA] The Illinois Rural Health Association's fifth annual meeting will be held March 23-24 in Effingham and will address issues ranging from health system reform to emergency medical services.

Using the theme "Building Rural Health Coalitions: Neighbors Helping Neighbors," the two-day event will include a presentation on health system reform by Denise Denton, president of the National Rural Health Association. A general session about recruiting physicians to rural areas and increasing access to primary care will be presented by Ron Myers, MD, a family physician, who operates a rural free clinic in Tchula, Miss. Other sessions will cover the politics of school-based clinics, ways to build hospital cooperatives, rural transportation, community leadership and mental health services in rural areas. For more information, contact the IRHA administrative office at Carle Center for Rural Health at (217) 383-3206. ■

PHYSICIAN FACTS

The uninsured by profession

Job groups with higher-than-average percentages of uninsured employees. On average, 17 percent of all working people have no insurance.



Source: Employee Benefit Research Institute

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Gubernatorial aspirants address health issues

PRIMARY RACES: Candidates agree that health care changes must be made, but their reform solutions vary. By Anna Chapman

[SPRINGFIELD] With health system reform topping the national agenda, localized reform is surfacing as a major issue for gubernatorial candidates as the March 15 primary approaches. Although not all the candidates agree that Illinois' health care system is in crisis, most believe access to care and cost containment are key elements of reform.

The upcoming Republican primary for the state's chief executive office pits first-term incumbent Gov. Jim Edgar against entrepreneur Jack Roeser. Candidates seeking the Democratic nomination include state Comptroller Dawn Clark Netsch, Cook County Board President Richard J. Phelan, Illinois Attorney General Roland Burris and trial attorney James Gierach. Except Burris, who could not be reached for comment, all the gubernatorial candidates included in this report shared their views on health-related issues with *Illinois Medicine*.

Edgar said he favors revising and fine-tuning the existing features of private insurance, and he recommends government support for those who are unable to afford insurance and "gap coverage" for workers between jobs.

Other Edgar priorities include improving access to care through reforms in the

doctors have not done their job. I know what it means to convince a jury that they should not have to punish with millions and millions of dollars."

Netsch said she opposes capping normal recovery and has reservations about capping noneconomic damages.

Edgar indicated that as Congress deliberates various health system reform bills, Illinois must begin moving forward with individual reforms, such as the insurance industry reforms he suggests. Netsch and Phelan said Illinois must prepare now to implement a national plan. "If it's true that something will be ready to pass out of Washington by the end of 1994, we should be ready to put our own version in place right after that," said Netsch, who favors universal access to care, a guaranteed package of benefits and some form of benefit security similar to that outlined in the Clinton plan. "The main thing is to get us moving," she said.

Phelan said he advocates creating a

system of community clinics staffed by primary care physicians to provide preventive and follow-up care to indigent patients. That system would reduce the use of emergency rooms for less-serious health complaints, he said, noting his efforts to bring such clinics to underserved areas of Cook County.

Roeser said he would implement primary care clinics. "A large majority of people are looking to fix up a cut or do something about their flu. That type of care should not be aimed at emergency rooms or hospitals at great cost."

Netsch cited Edgar's Healthy Moms/Healthy Kids program as a possi-

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Blue Cross Blue Shield



REPORT

FOR *Illinois Physicians*

NEW MEDICARE COVERAGE POLICIES

Prostate Specific Antigen (PSA) - CPT Code 84153

Prostate Specific Antigen (PSA), is covered as a diagnostic, but not a screening test by Medicare Part B. **Effective February 1, 1994**, the Illinois carrier will cover PSA for the following diagnoses:

ICD-9-CM CODE	DIAGNOSIS
185	Malignant neoplasm of prostate
198.82	Secondary malignant neoplasm of prostate
233.4	Carcinoma in situ of prostate
236.5	Neoplasm of uncertain behavior of prostate
600	Hyperplasia of prostate
V10.46	Personal history of malignant neoplasm of prostate

Dual Energy X-ray Absorptionmetry (DEXA) - CPT Code 76075

Effective February 1, 1994, the Illinois carrier will cover Dual Energy X-ray Absorptionmetry (DEXA), when necessary for the measurement of bone mass. The clinical indications for which one baseline DEXA study of one site will be allowed, are:

- (1) **In estrogen deficient women**, to diagnose significantly low bone mass in order to make decisions about hormone replacement therapy (ICD-9-CM Codes 256.2, 256.3).
- (2) **In patients with vertebral abnormalities or roentgenographic osteopenia**, to diagnose spinal osteoporosis in order to make decisions about further diagnostic evaluation and therapy (ICD-9-CM Codes 733.00-733.09, 733.1).
- (3) **In patients receiving long-term glucocorticoid therapy**, for various conditions, such as rheumatoid arthritis, chronic active hepatitis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease, to diagnose low bone mass in order to adjust therapy (ICD-9-CM Codes 491.20, 491.21, 493.10-493.90, 555.0-555.9, 556, 571.49, 714.0).
- (4) **In patients with primary asymptomatic hyperparathyroidism**, to diagnose low bone mass, in order to identify those at risk of severe skeletal disease who may be candidates for surgical intervention (ICD-9-CM Code 252.0).

Repeat DEXA studies of one site will be covered, only when used for determining efficacy of therapy. Coverage intervals for indications (1) and (2) will be 12 months, and coverage intervals for indications (3) and (4) will be 6 months. DEXA is **not** covered as screening test for osteoporosis prophylaxis.

(Issue: 02/11/94 - DB)

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today's investment will
yield savings tomorrow
in terms of preventing
major health problems.*

small-group insurance market, insurance portability and increased emphasis on primary and preventive care. Focusing on primary care is also a priority for other gubernatorial candidates, including Netsch, Phelan, Roeser and Gierach.

Most of the candidates voiced strong opinions – pro and con – about enacting more tort reforms in Illinois. "I have consistently supported changes in medical malpractice laws that cap the amount of damages that can be awarded for noneconomic reasons," Edgar said.

Roeser said he also favors caps on noneconomic damages in malpractice suits. The Democratic candidates were less supportive of caps. Gierach said he would not rule out caps as a method of containing health care costs. But Phelan, a former trial attorney, said that he is "not interested in taking away the right of a person to sue" and that he does not support a cap on noneconomic awards. He added, however, that he opposes a proliferation of frivolous lawsuits. "The reason those verdicts run away is because the lawyers representing those

Statehouse races



The March 15 primary elections include many races for seats in the Illinois Senate and House of Representatives that are of interest to organized medicine. The following overview of several of those races provides

the candidates' positions on health system reform and a \$250,000 cap on noneconomic damages in medical malpractice cases. The races are grouped by district. To determine your district, check your voter registration card. *Illinois Medicine's* coverage of General Assembly primaries will continue in the Feb. 25 issue.

Senate

20th district

Beverly Fawell (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: I advocate reducing administrative waste, enacting Medicaid reforms, and using pension plans, IRAs and 401(k)s for tax-free insurance purchases. I also support insurance reforms such as eliminating pre-existing condition limitations and encouraging coverage of preventive health programs.

29th district

Robert C. Acri (R)

System I recommend: Current system with modifications

Funding sources I support: Combination of employer, employee and government funding

Clinton plan: Oppose

Other plans supported: None proposed to date have merit.

\$250,000 cap on noneconomic damages: I support the concept of a cap, but I am not sure whether \$250,000 is the appropriate amount.

Other reform suggestions: Control costs, shift costs among employers and employees by advocating cafeteria plans and medical IRAs, and provide an environment that encourages insurance companies to provide health insurance to Illinois citizens

Kathleen Parker (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: We must reform the system; however, we must be careful that the quality of care is not jeopardized. The way to reform the health care system in Illinois is through tort reform, so that malpractice costs can be brought under control to provide affordable health care for all.

Grace Mary Stern (D)

System I recommend: None stated

Funding sources I support: Combination of government funding and employer-paid benefits and sin taxes

Clinton plan: Support, but let's discuss all options

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: Reform must include universal access, insurance portability, elimination of pre-existing condition limitations and, I hope, freedom of choice.

41st district

Kirk Dillard (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: None in its entirety, but I lean toward the Republican congressional plans to start negotiations

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Medicaid reform, more personal responsibility for one's health, small business changes to encourage insurance pools, more efficient utilization of health care institutions and services

House of Representatives

12th district

Sara Feigenholtz (D)

System I recommend: I tentatively support a private-public partnership

Funding sources I support: Combination of government funding and employer-paid benefits; possibly sin taxes

Clinton plan: Although the plan is still fluid, I will commit to supporting universal accessibility, eliminating pre-existing condition restrictions and protecting Medicaid.

Other plans supported: I have yet to see a plan I fully support.

\$250,000 cap on noneconomic damages: A flat cap of \$250,000 would not be fair in all instances.

Other reform suggestions: I have no quick fix. However, I recognize how multidimensional the issue of health care is in Illinois and that reform must address the system in its entirety, including, but not limited to, prevention, quality care, access, financial protection from health care expenses and an overhaul of the

state's Medicare system. We should concentrate on keeping what works and reforming the rest.

34th district

John Lee Bingham (D)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits and sin taxes

Clinton plan: Support

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: I don't see tort reform addressed nearly enough. There is too much of a burden on medical professionals. I also advocate universal access, a simplified universal claim form with faster turnaround of payment for services performed, coverage for individuals with pre-existing conditions and a system that encourages preventive care, exercise and good nutrition.

Thomas Foley (D)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Support in part

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Elimination of administrative waste, more efficient use of health care facilities, Medicaid reforms, antitrust reform, insurance reforms such as community rating and elimination of pre-existing condition clauses, requirement that insurers cover preventive health programs, and use of pension plans, IRAs and 401(k)s for tax-free insurance purchases

36th district

Dave Heilmann (R)

System I recommend: Public-private partnership

Funding sources I support: Employer mandates, combination of government funding and employer-paid benefits, and sin taxes

Clinton plan: Oppose

Other plans supported: I have read and support the ISMS April 1993 health care reform plan.

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: I do not believe we need further government intrusion into the health care industry. A system controlled more by the marketplace and based on competition among health insurers is desirable. I also support managed care systems that emphasize preventive care, elimination of pre-existing condition limitations, standardized claim forms and strong incentives for behavior modification.

Maureen Murphy (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, establishment of insurance purchasing pools among small businesses

Clinton plan: Oppose

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor



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Chicago, IL 60611
312/915-7174

Other reform suggestions: Elimination of fraud and waste, better prevention, patient-controlled medical bank accounts, and consumer-oriented service delivery, such as satellite prenatal, gerontology and immunization clinics through counties and townships

38th district

Larry Wennlund (R)

System I recommend: The current system
Funding sources I support: Current sources

Clinton plan: Oppose

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: I'm not convinced the system's broken. We currently have the best health care in the world, so why fix it? However, we could create tax-free savings plans for health care and use IRAs and 401(k)s for uncovered expenses. The indigent and uninsured are currently receiving health care, but a plan should be implemented to serve them at less cost.

Victoria D. Prainito (R)

System I recommend: Uncertain

Funding sources I support: Combination of government funding and employer-paid benefits and sin taxes

Clinton plan: Oppose

Other plans supported: Need more data to make an informed decision

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: We need to develop a system that helps everyone receive care and treatment, without causing undue hardship and delay for patients. Too many people are uninsured; however, I have not seen a viable alternative yet. I am open-minded on this issue.

56th district

Carolyn H. Krause (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits and sin taxes

Clinton plan: Oppose

Other plans supported: I support a plan that provides increased involvement of the private sector, preservation of patients' rights to select their own doctor, insurance portability, elimination of pre-existing condition clauses and other streamlining measures.

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: We must reform the system so that everyone has access to health insurance. I want a program that insures all workers and enables insurance companies to remain active in this field. There must be incentives for small businesses to insure their employees, and government must create better insurance pools.

59th district

Mary Beattie (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: Cooper plan

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: I believe Gov. Jim Edgar was on the right track in his State of the State address by suggesting that Illinois can and should enact legislation that guarantees access, eliminates pre-existing conditions and moves toward making health care affordable to all citizens.

63rd district

Ann Hughes (R)

System I recommend: Strengthen private system by expanding the options avail-

able, reforming insurance and including consumers in decision making about risk management and health care options

Funding sources I support: Individuals, either directly or through insurance purchased by employers without a mandate

Clinton plan: Oppose

Other plans supported: Maybe Hastert plan

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Equal tax treatment for all, portability, managed care for Medicaid, medical IRAs, elimination of mandates on health insurance and more opportunity for pooling small employers

Virginia D. Peschke (R)

System I recommend: Public-private partnership

Funding sources I support: Sin taxes and private premiums

Clinton plan: Uncertain

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor caps, but I don't know what the proper amount should be; perhaps it should be less

Other reform suggestions: Reduction of paperwork would be a start. This often delays care, even in emergency rooms and adds significantly to the cost of medicine. Forms should be standardized.

(Continued on page 8)



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EDITORIAL

ISMS wants to hear from you

During his recent State of the Union address, President Clinton reiterated some of his views on health system reform. Although no one knows which plan or which elements of any plan will ultimately be passed by Congress, it's safe to say that the health care delivery system will significantly change. In fact, drastic changes have already occurred in states like California. Changes are even taking place here in Illinois – in Winnebago, Madison, St. Clair, Cook and Macon counties, to name a few.

ISMS takes those changes and our responsibility to our members very seriously. That's why the Society launched the "Health Reform: Taking Charge of Change" health reform education program. And that's why we want to know about your concerns and any changes in your medical practice environment.

By now, you should have received an ISMS brochure titled "Looking to Your Future." It includes a business reply card on which you can note your situation and your preferences for future ISMS services. If you haven't already completed and returned the card, please do so. To tailor Society programs and services that meet your needs, we must have your input.

A series of town meetings sponsored by ISMS and various county medical

societies is nearing completion. Those discussions, in different locations around the state, have allowed physicians, patients, legislators and business leaders to exchange viewpoints and concerns about reform. At the meetings, ISMS-produced patient education kits were distributed. The kits, which will also be mailed to all members, include a poster and questions and answers about reform. They are designed to facilitate discussions between physicians and patients.

The Society is also studying the feasibility of developing a "physician network" for our members. That study will also take a look at which options ISMS could provide our members to help them in the changing medical marketplace. In addition, ISMS is sending representatives all over the state to meet with you, your hospital medical staff and your county medical society. That way, you can talk face-to-face with someone about your concerns, circumstances and priorities.

Even if you haven't been very active in ISMS or your county medical society before now, this is the time to express your views. We need to hear from grassroots physicians across the state so that we can provide the tools you'll need. Make time to meet with ISMS representatives. Remember, your responsiveness may help determine how you and your patients will be affected by reform.

PRESIDENT'S LETTER

Moving from ideals to realities



By Arthur R. Traugott, MD

The Jan. 22 meeting of ISMS' Board of Trustees marked something of a turning point in my service as president. Before then, when I visited my colleagues in their home counties, my discussions centered around the ISMS plan for health care reform, which was adopted last April. We talked about the components of an ideally reformed system. I am proud that the commonsense ideas we advanced have helped the debate progress.

Now that the debate has moved to Congress, however, we have a new set of opportunities and challenges. The top challenge now is to focus our efforts on achieving the specific reforms necessary to maintain high-quality patient care within the framework of political possibilities. In short, it is time to move from ideals to realities.

Any reform plan to be supported by physicians must contain two core elements. First, it must include antitrust reforms that enable physicians and their patients to stand up to big bureaucracies and insurance companies whose economic edicts intrude into the doctor-patient relationship and threaten the quality of our patients' care. Without significant changes in the antitrust laws, bureaucratic cost cutting could override patient advocacy.

As I've told our colleagues, poorly designed reform would cause our physician ethic to deteriorate. We would become primarily responsible not to our patients but to our patients' payers. It may be appropriate for veterinarians, for example, to be responsible to payers rather than to patients, but it certainly is not appropriate for physicians, who treat human patients, to do so.

Second, reform must contain meaningful, effective liability

reform. That means continued full recovery of economic damages with a reasonable \$250,000 cap on noneconomic awards. Effective cost control cannot be realized without tort reform, and tort reform cannot be effective without a cap on noneconomic awards.

The evolving debate in Congress has raised the question of whether health care coverage is a fundamental right. I recently responded to a guest editorial in the St. Louis *Post-Dispatch* in which the writer claimed that health care is a fundamental right but failed to address the question of who is responsible for providing it. Let's not forget that the right of 37 million uninsured men, women and children to receive health care is observed daily in physicians' offices, free clinics and emergency rooms. However, this is a stopgap solution at best.

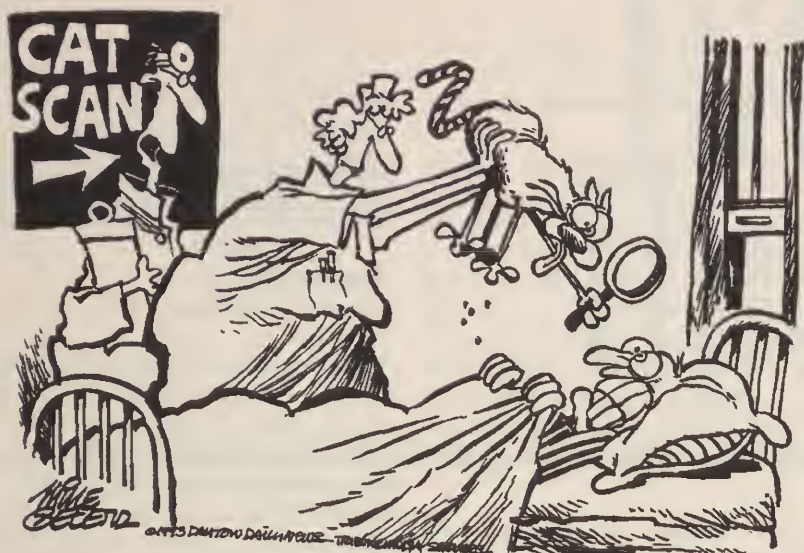
Physicians support the goals of the various reform plans that aim to increase access and security of coverage. Our health care system needs change. However, change that limits choices, reduces quality and leads to bureau-

cratic control of the relationship between patients and doctors is not change for the better.

Whether people believe health coverage is a right to be provided by government or a responsibility people must primarily meet for themselves (with government assistance when necessary), we must not allow excellence to be reformed out of our health care system.

The plans before Congress demonstrate that some thoughtful leaders recognize that it is possible to develop a patient-first health reform plan with effective cost controls. Our experience proves it is essential. The time has come to get it done.

Physicians support the goals of the various reform plans that aim to increase access and security of coverage.



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"You have to expect some cutbacks with the Clinton health plan. ..."

LETTERS

Attorney misdeeds deserve attention

I was pleased to see the story "Lawyer steals vaccine victims' compensation" reported in the Dec. 17 issue of *Illinois Medicine*. I feel that physicians are unjustly singled out for criticism by the general population, particularly the media.

It is distressing to read about this kind of greed and fraud by an attorney. However, I don't understand why this story was reported only in *Illinois Medicine*, and I did not see it on television. When it comes to bad-

mouthed physicians, television and other media become vocal critics.

If the media is soft on greedy attorneys, why doesn't ISMS expose more of them? After all, we let everyone discipline physicians in the name of health reform. Why not fight harder for "legal reform" in this country?

— Vijay Patel, MD
Chicago

If you have an opinion on a story published in Illinois Medicine, please share it with other readers. Send your letter to Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. We reserve the right to edit letters for space and style.

ISMS, Exchange annual meetings set for April

The 1994 ISMS House of Delegates Annual Meeting will be held April 22-24 at the Oak Brook Hills Hotel, 31st Street and Midwest Road in Oak Brook. Reference committee testimony will be taken on Friday, April 22, and House deliberations of resolutions will occur on Saturday, April 23, and Sunday, April 24.

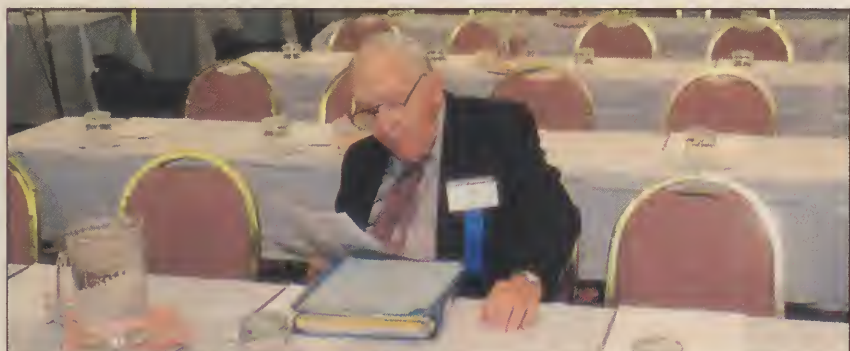
According to ISMS policy, only delegates and voting members of the House can submit resolutions. However, any ISMS member may attend the meeting and testify before reference committees and in the House. The deadline for receipt of resolutions is the close of business March 22; a March 22 postmark is insufficient. Resolutions received at ISMS offices after that date will be reviewed by the Committee on Rules and Order of

Business to determine whether the House will consider them. Only resolutions received by the deadline will be included in delegate handbooks.

Resolutions should be addressed to the attention of Mr. Richard Ott, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

The ISMIE Annual Meeting will also be held at the Oak Brook Hills Hotel. It is scheduled for Wednesday, April 20. ISMIE board elections will be held at that time.

Informational materials will soon be mailed to House of Delegates members with their meeting packets. For more information, contact ISMS at (312) 782-1654 or (800) 782-ISMS, ext. 1160. ■



Wm. Daniels/The Photo Partners

GUEST EDITORIAL

Physicians have important role in Alzheimer's treatment

By Mary C. Agne, MD

She used to be fine, but more and more, she forgets things, uses poor judgment, can't manage familiar tasks, can't remember the right word, is changing in behavior and personality, has problems with abstract thinking, gets lost (even near home), has no initiative and misplaces things."

Maybe during a routine examination, you have heard similar complaints from a patient or a patient's spouse. You may have thought, "He's just getting older," or "She's overworked." But those types of memory loss, confusion and disorientation are common symptoms of a demential illness.

Alzheimer's disease is the most common form of dementia and is the fourth leading cause of death among adults. About 4 million Americans suffer from Alzheimer's disease, and with our aging population, that number is expected to increase to 14 million by the year 2050.

Alzheimer's disease claims more than 100,000 lives each year. An estimated 10 percent of Americans over 65, and nearly half of those over 85, are afflicted. Those patients can live from three to 20 years or more from the onset of symptoms. And because most of them receive care at home, it is quite likely you have encountered or will encounter an Alzheimer's patient in your practice.

As physicians, we have two critical roles to play when Alzheimer's disease is suspected: establishing an accurate diagnosis as early as possible and providing ongoing support and education to the family. When assigning a diagnosis, it is important to rule out reversible causes of the symptoms, such as depression, adverse drug reactions, strokes, metabolic changes or nutritional deficiencies. An early diagnosis often allows patients to participate in decision making about such issues as advanced health care directives, financial planning and other legal decisions.

The following characteristics and behaviors may be symptoms of Alzheimer's:

- *Recent memory loss affecting job skills.* The patient forgets things more frequently and doesn't remember them later. The person repeatedly asks the same question.
- *Poor or decreased judgment.* For example, the patient may forget that he or she is supervising a child and may leave the house. Or the individual may begin dressing inappropriately.
- *Difficulty performing familiar tasks.* The patient may cook a meal and then not only forget to serve it but forget that he or she prepared it.
- *Problems with language.* The individual may forget simple words or substitute inappropriate words in sentences, making them incomprehensible.

• *Changes in mood, behavior or personality.* The patient may exhibit rapid mood swings or extreme emotions for no apparent reason.

• *Problems with abstract thinking.* The patient may suddenly have difficulty balancing a checkbook and forget what to do with the numbers.

• *Disorientation about times and places.* The individual may get lost in familiar areas. He or she may not know even the approximate time of day.

• *Loss of initiative.* The patient may be exceptionally passive, requiring cues and prompting to become involved in activities.

• *Misplacement of objects.* The individual may put objects in inappropriate places.

When the diagnosis is Alzheimer's, patients and their family members rely on physicians to help them understand the course of the disease, participate in making difficult decisions and direct the family to appropriate community resources.

In helping patients and families manage this disease, we should explain the types of behavioral changes they can expect, so that the home environment can be changed accordingly or plans for the patient's security can be made. Enrollment in a program such as the Safe Return Program of the Alzheimer's Disease and Related Disorders Association can help families cope with a patient who wanders away from home. This is one of the most common behaviors associated with the disease. For more information about this and other programs, contact the ADRDA at (800) 272-3900.

Throughout the progression of Alzheimer's, patients and family members will turn to their physicians to help them make difficult decisions. You may be asked to determine when it no longer is safe for a patient to drive. Or you may be consulted about determining when nursing home placement is necessary.

Finally, patients and their families often count on physicians to direct them to appropriate community resources. You may be asked to recommend adult day care programs or respite services. The ADRDA can be one of the most useful community resources available to patients, families and health care professionals. With more than 220 chapters nationwide, including 10 serving Illinois, the ADRDA provides a wide range of programs and services to support patients and their families.

Although there is currently no cure for Alzheimer's disease, the ability to treat and manage this disease is a strong motivation for physicians to recognize the symptoms and provide an early diagnosis. Until a cure is found, we can try to help patients function as well as possible throughout the course of this disease. ■



Dr. Agne is an assistant professor of family medicine at the Southern Illinois University School of Medicine's Belleville residency program. She is also a member of the local advisory board of the ADRDA.

Statehouse races

(Continued from page 5)

Many procedures could be done by properly trained technicians. There is a shortage of physical and occupational therapists, and no attempt is being made by our state universities to correct this problem. Government insurance programs such as Medicaid are absurdly fraught with paperwork requirements — even more than private programs. Patients also need to take more responsibility for their own care. The whole system needs to be overhauled before any universal program can be implemented.

65th district

Patricia Reid Lindner (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, establishment of medical savings accounts and possibly provision of tax credits to low-income families that do not qualify for Medicaid

Clinton plan: Oppose

Other plans supported: There have been a variety of plans offered by Senate Republicans, House Republicans and conserva-

tive Republicans, and I would have to study these to choose. I probably would support a combination of all of them.

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: We need to address Medicaid problems, such as fraud, because the program is eating up our state budget. People on Medicaid ought to have a primary care physician or HMO to manage their care and should pay at least some small amount of their own money to contribute to their care. Insurance portability and medical IRAs should also be considered. We left personal responsibility out of

our health care plans, and we need to encourage people to take preventive measures for their health and watch what they spend, just as they would for any other items in their budget.

66th district

Douglas Hoeft (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits and sin taxes

Clinton plan: Oppose

Other plans supported: Hastert plan

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Keep the government out of the medical field. Limit the number of claims against doctors that are now allowed in court. I would vote for the English system, in which the party who loses a lawsuit pays the other party's expenses.

68th district

Ron Wait (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: I have not yet seen a plan I can fully support.

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: We should not throw out an entire health care system because some parts are broken. We have a good foundation, and we should work from that base. I would advocate a health care summit in Illinois involving all aspects and components of the system. We can then pool our ideas and resources and present them to the governor and our federal legislators.

Joe Wiegand (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits; sin taxes; vouchers and medisave programs

Clinton plan: Oppose

Other plans supported: Growing fondness for House Republican plan, H.R. 3080

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: For most Americans, health care is excellent. Maintaining choice of physician and coverage is crucial. Also we should help families and communities establish preventive health programs that reinforce the concept of personal responsibility and work with health care professionals to accomplish this and other mutual goals.

Joe Gulotta (D)

System I recommend: Public-private partnership

Funding sources I support: None stated

Clinton plan: Oppose

Other plans supported: Government funding for abortions and rationing based on perceived quality of life

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: I favor programs to provide physicians for rural and inner-city areas. ■



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 for April

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ISMIE Update

General Assembly candidates state their positions on caps

PAGE 4

Court expands hospitals' liability for nonemployee physicians

INDEPENDENT CONTRACTORS: Physician-hospital relationships may face significant changes because of a state Supreme Court decision. By Gina Kimmey

[SYCAMORE] A recent Illinois Supreme Court ruling could have implications for physicians' relationships with hospitals and patients. The ruling stated that hospitals may be held vicariously liable for the negligence of physicians who are on their medical staffs and are independent contractors. The court's decision in *Gilbert vs. Sycamore Municipal Hospital* represents a significant step toward establishing hospital liability separate from physicians' liability, said William J. Rogers, a Chicago attorney with Bollinger, Ruberry and Garvey.

If hospitals are subjected to increased liability, there could be significant repercussions for physician-hospital relationships, Rogers said. Hospitals may require indemnity agreements from nonemployee staff physicians.

In addition, physician independent contractors may be a thing of the past, as hospitals may find it more economical to

hire physicians as employees, said Paul Craig, a Chicago attorney with the firm Katten, Muchin and Zavis.

"Some people think that ER contract groups will go by the wayside," Craig said. "Part of the reason these groups were set up was so the hospital could avoid the liability, but if they are going to be liable anyway, then why not kick out the middleman."

According to court records, the defendant hospital's emergency room services were considered a function of the hospital, in which the staff physicians were independent contractors.

In the 1981 incident, the plaintiff arrived by ambulance at the hospital ER, complaining of chest pain. He was seen by an on-call staff physician, who ran several tests, prescribed pain medication and sent the patient home. Later that evening, the patient experienced a heart attack and died.

The patient's estate sued the

physician and the hospital for medical malpractice and wrongful death. The physician settled, but the hospital moved for summary judgment, stating it was not liable, because the physician was not a hospital employee. The trial court granted summary judgment in favor of the hospital, and the appellate court upheld the decision. But in October, Illinois' Supreme Court reversed the decision, citing the doctrine of apparent authority.

The court ruled that under that doctrine, a "hospital can be held vicariously liable for the negligent acts of a physician providing care at the hospital, regardless of whether the physician is an independent contractor, unless the patient knows or should have known that the physician is an independent contractor."

The decision may make it more difficult for hospitals to defend themselves in lawsuits, Craig said. Prior to the decision,

plaintiffs had to prove "detrimental reliance," showing that they thought doctors were hospital employees and that if they had known the physicians were independent contractors, they would have chosen a different hospital, he said. But now plaintiffs must prove only "justifiable reliance," meaning they do not have to say they would have done anything differently if they had known the real relationship between the hospital and the physician.

"The idea of apparent authority, or hospital liability for a nonemployee physician, has been kicking around for a long time," Craig explained. "I think the broader implications of this case are that it concerns all hospital-based physicians. In fact, there is language in the case that suggests it might even be construed to apply to all staff physicians in a hospital. Although it is not clear that that is what the case holds, some people could read it that way."

THE DECISION also forces hospitals to notify patients that certain physicians are not hospital employees, Rogers said. That poses a conflict between hospitals' current marketing efforts claiming diverse staff and wide-ranging services and their reluctance to accept liability for

nonemployee physicians, he added.

"On one hand, [hospitals] are bringing people in by saying, 'Look at all these marvelous facilities and marvelous staff people that we have,'" Rogers said. "On the other hand, they want to disassociate themselves from liability for a lot of those pathologists, radiologists, emergency room physicians, et cetera. They can't have it both ways."

"[Hospitals] don't want to be liable for the doctors, but the doctors are in effect [their] bread and butter. Without the doctors there, the hospital wouldn't function," Craig added. "What people are concerned about — even people who don't think that this case changed the law that much — is that it shifted the burden to the hospital to have to prove to the public that the doctor was not its agent or employee."

"You don't want to put a sign on the back of every doctor, saying, 'I'm not an employee of the hospital,' and you don't want a huge neon light in the ER saying, 'We are not responsible for the doctors working here,'" Craig continued. "But the hospitals are now going to have to debate how to let the public know that certain physicians on their staff are not hospital employees." ■

MALPRACTICE ROUNDUP

Duty of care exists in third-party exam

A physician owed a duty of care to a woman he examined in connection with a personal injury suit, according to a Colorado court of appeals. As reported in the medicolegal digest *The Citation*, a patient sued a bus company for injuries she sustained in a bus accident. During an examination by a physician who was chosen by the bus owner, the patient noted that she had undergone three spinal surgeries for a back condition and was currently in rehabilitative therapy. After the initial exam, the physician referred the patient to another facility for an additional examination that included exercises testing the patient's strength and range of motion.

The patient subsequently sued the referring physician, alleging she suffered injuries during that examination. The physician claimed he was not liable for any injuries the patient incurred during an examination performed by someone else. The trial court found in favor of the defendant. The ruling stated that the physician did not owe the plaintiff a duty of care, since he was not retained by the bus company to provide medical care for the patient, nor was he paid by the plaintiff for any services she received.

The appeals court, however, reversed that judgment. In its ruling, the court said that by accepting the responsibility for examining the patient, the physician "agreed to perform his common-law duty to use reasonable care and his best judgment in exercising his skill" not to harm her. The court concluded that barring

negligence during the other examination, the physician may be liable for "foreseeable negligence" in ordering the exam. ■

Physicians not bound to reveal patients' life expectancy

The California Supreme Court affirmed a trial court's ruling that physicians do not have an absolute duty to notify terminally ill patients about their life expectancy, according to *Medical Malpractice Law & Strategy*.

The family of a deceased cancer patient filed suit against the treating physicians, claiming that because the patient failed to receive information about his life expectancy, he made decisions that resulted in a loss of more than \$1 million to his heirs. A jury found in favor of the physicians, but an appeals court reversed the verdict.

The state Supreme Court, however, said that to obtain informed consent, physicians have a legal duty to disclose only the "potential of death or serious harm known to be inherent in a given procedure and an explanation in lay terms of the complications that might possibly occur." Because statistical life expectancy information "lies outside the significant risks associated with a given treatment," physicians are required to provide this information only if it is the widely accepted standard of practice to do so, the court said.

The court also dismissed the allegation that physicians must give life expectancy information so that patients can use it to make business decisions. ■

LAB REGULATIONS

Physicians cope with CLIA compliance

Doctors share their inspection experiences, and IDPH tells you what to expect.

BY KATHLEEN FURORE

CLIA. The acronym for the Clinical Laboratory Improvement Amendments of 1988 has become a four-letter word to some physicians who fear that federal regulations for office laboratory tests could hinder their ability to provide cost-effective lab services. In complying with CLIA regulations, physicians face substantial registration, certification and inspection fees and the burden of documenting information ranging from maintenance of their microscopes to the daily temperature of refrigerators holding their patients' throat cultures. As a result of the extra time and money expended, doctors are concerned that the cost of performing lab services will soar. And that, some believe, could ultimately affect the cost and quality of care for their patients.

"In our office, we haven't improved the quality of any of our tests [because of CLIA], because no improvement is needed. We are already operating at extraordinarily high standards. We aren't doing anything differently except documenting, documenting, documenting," said William H. Barrows, MD, a Chicago pediatrician. Dr. Barrows noted that he has spent "hundreds of hours" preparing for a CLIA inspection, which he suspects will occur soon.

"I almost said, 'Just forget about the lab.' A lot of offices have stopped doing lab tests," Dr. Barrows continued, characterizing responses to CLIA's documentation requirements. Those regulations force him to record the temperature of his lab's refrigerator and incubator daily, he said. "But I have a tremendous compassion for kids. I do throat cultures almost every day of the year, and if I sent them out, I wouldn't get the results until two days later at best. With our own

lab, we always have results the next morning. So if a child has strep throat, I can have him or her on antibiotics within 24 hours or less after the first visit."

That's a good enough reason to scrutinize the "triple columns of very fine print that tell us what we have to do" and "make up a four-inch ring binder for CLIA," Dr. Barrows said.

AS A RESULT of a late-1993 inspection, an allergist in private practice on Chicago's North Shore has closed his office lab. The physician, who asked to not be identified, said he had reviewed the requirements and updated his documentation to the extent he believed was required for the one moderately complex test he performed. The test is a smear for eosinophils, which identify signs of allergies. Despite his preparation, the physician failed to pass the inspection.

"The inspector started asking questions like 'How do you know your microscope is working?'" the allergist recalled. "I said, 'If I can see through it, I know it's working.' But I was told that wasn't adequate, because I didn't have the procedure for detecting whether the microscope was working documented in my manual."

The physician was also cited for failure to specify the procedures he followed when his microscope broke, failure to include his address on his lab slips,

We aren't doing anything differently except documenting, documenting, documenting.

LAB REGULATIONS

and failure to date the receipt of samples in the lab (even though he listed the date the samples were taken in the examining rooms and immediately walked the samples to the lab, which is a few steps away).

"The end result of all of this is that I stopped doing that test in my office," said the allergist, noting that the cost of registering with the U.S. Health Care Financing Administration and complying with CLIA regulations was too prohibitive for his small office. "I now work with [an outside lab], which has meant a 30-percent cost increase to me, and I've had to pass that on to my patients. The truth is, we did a better job. I'm never really sure who's doing and reading the tests."

The allergist paraphrased a sentiment expressed by the inspector who conducted his CLIA inspection: "She said that the problem with the whole thing is that it's a one-size-fits-all law. I have a small office in which I'm doing one test, and I have to adhere to the same regulations as a large, multistate lab."

AS AN OB/GYN in Decatur, Mary E. Herald, MD, had always used her office lab to process pregnancy tests, blood counts, mini-cultures of urine and screens for

counts, despite the fact that the lease for the machines they'd always used did not expire for two more years.

"To qualify to use the old leased machines, we had to move from the waived up to the moderately complex level. Then we were sent a 12-page form to comply with the more complex lab requirements. And at that stage, we said, 'No!' We basically ate our lease and invested in the new machines. Under CLIA, blood counts can be waived if they're done on certain instruments."

Dr. Herald said physicians in her office were relieved about the CLIA inspection. "We were dreading it, but the inspector was very nice and didn't hassle us." However, she concurred with Dr. Barrows and the allergist about the challenge of the paperwork involved.

"The paperwork is the awful part; it increases the amount of office staff work," Dr. Herald said. "If you have enough volume and enough doctors, it's worthwhile to set up a complex lab and do it all. But with just three doctors and one nurse practitioner in our practice, it wasn't worth our while."

ONE WAY TO ALLEVIATE the anxiety created by the prospect of an inspection is to know what to expect. To help in that area, the Illinois Department of Public Health is working on a document that spells out the details of a typical survey. IDPH is conducting statewide CLIA inspections for HCFA. "This is a new process, and like anything new, it is a little scary. We're here to help," said a spokesperson for IDPH.

The spokesperson emphasized that inspectors will not drop by unannounced. "Everyone will have at least two weeks to prepare [for routine inspections]." He added that inspectors call to set up appointments for inspections, which normally last about four hours. Someone familiar with office testing procedures should plan to be present for most of that four-hour period, he advised.

Physicians are concerned about the type and amount of documentation CLIA inspectors want to see. The IDPH spokesperson said physicians can stop worrying about sharing patients' private medical records with inspectors. "Our inspectors are not ordinarily interested in seeing those records — they only want to see where the doctor writes test orders and test results. If doctors maintain orders and test reports separately, [inspectors] won't necessarily need to see any medical records."

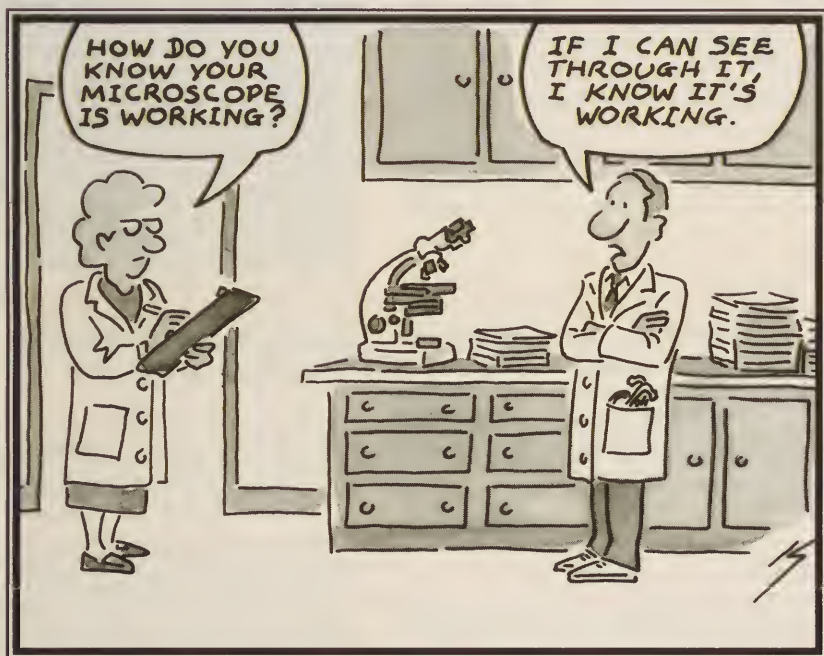
Although inspectors must sometimes access patient records, they are bound by strict rules regarding confidentiality, said IDPH Director John R. Lumpkin, MD. If inspectors are found to be using patient information for purposes other than those required by the CLIA regulations, they face investigation by the Illinois State Police and possible criminal sanctions, he said.

To pass a CLIA inspection, however, there are a variety of documents physicians will have to produce, according to IDPH. They include the following:

- ◆ A written quality assurance plan. The IDPH spokesperson described this as an ongoing study of the various processes involved in collecting and testing specimens and reporting results. He said it differs from routine quality control in that it is a "big picture" approach to assess quality over the long term, detailing daily quality control failures that occurred and were corrected.

- ◆ Quality control records that show a physician has run two levels of controls for each test for each day testing was done. IDPH said the documentation must

(Continued on page 12)



cholesterol and diabetes. Today, as the result of CLIA regulations and a recent CLIA inspection, Dr. Herald no longer offers urinalysis and cholesterol screening to her patients.

"We'd thought that all the tests we performed were waived tests. The only one we thought that wasn't waived was the cholesterol screening, so we dropped that," Dr. Herald explained. "But then we found out that taking urine cultures was considered moderately complex, so we don't do that anymore. That's had an impact, because having it done at a hospital costs about \$60, and our mini-screens were about \$15. And I know [CLIA regulations] have impacted those organizations like Planned Parenthood that test for sexually transmitted diseases. It's my understanding that [these organizations] used to do the cultures and send them to the county health departments, where they were read for free. But they can't do that anymore, because they can't afford the expense of setting up a complex lab."

Dr. Herald also said her practice invested in new testing machinery so that the physicians in the office could continue offering hemoglobin and hematocrit

ISMS and IDPH discuss physicians' concerns

Physician concerns about lab inspections mandated by the Clinical Laboratory Improvement Amendments of 1988 were discussed during a Jan. 5 meeting of the ISMS Medical Services Committee. Representatives from the Illinois Department of Public Health answered questions regarding unannounced inspections and the confidentiality of patient records during the inspection process. IDPH regulates office labs and conducts CLIA inspections for the U.S. Health Care Financing Administration.

According to IDPH, notice is always provided for routine lab inspections. Since Oct. 5, physicians have received two-weeks' notice of routine inspections. Previously, IDPH had provided

only three days' notice, said a spokesperson for the department. She stressed, however, that if inspectors detect problems with lab procedures during routine inspections, the department is required by federal regulations to conduct an unannounced follow-up inspection. "[Physicians] know IDPH will be back; they just don't know when," she added.

If IDPH receives a complaint about a doctor's office lab – such as a problem with cleanliness or infection-control techniques – he or she will be subject to an unannounced inspection, according to the department. Unannounced inspections like these are rare, though. To date, IDPH has surveyed more than 400 physician office labs under the

CLIA program, and only 10 were unannounced, said IDPH Director John R. Lumpkin, MD.

At the meeting, physicians also expressed concern about inspectors' requests to review patient records. Doctors said they worried about possible violations of patients' confidentiality rights. According to IDPH officials, however, federal regulations require inspectors to retrieve only limited information from patient records. Specifically, inspectors must look for documentation of physicians' orders for lab tests and the results of those tests, according to IDPH. Often, that information is available only in patient records, the department said.

ISMS recommends that physicians

who are concerned about patient confidentiality document all test orders and results in an office lab log. This will provide easy access to appropriate information for inspectors, which could save time for a physician's office staff during an inspection. However, during an inspection prompted by a patient complaint, a log may be insufficient, added Dr. Lumpkin. In those cases, inspectors may need to review the complaining patient's chart and several others to mask the individual's identity, he added.

Physicians who have questions about CLIA may call the ISMS department of medical services at (312) 782-1654 or (800) 782-ISMS.

— Gina Kimmey

CLIA

(Continued from page 11)

tie the control results to patient results. "One of the simplest ways to do this is to use a master log and write everything in that log – it keeps a wonderful record for the physician and inspector. It is an efficient, though not the only [acceptable], approach."

◆ Documentation of qualifications of personnel supervising or directing testing. Required documents include high

school diplomas and records of specialty training or experience.

◆ Records of employee competency exams. CLIA regulations require that employees pass annual competency exams. IDPH said the requirements are detailed in CLIA compliance materials and suggested that physicians familiarize themselves with the rules that apply to the tests.

◆ Authorization lists that document each test each individual is authorized to

perform. Directors must also provide information telling inspectors if those individuals are authorized to perform the tests with or without supervision and review.

IDPH emphasized that physicians will be given time to correct any deficiencies identified by CLIA inspectors. Physicians are encouraged to obtain a copy of inspector guidelines (Publication No. PB92146174). They cost \$39.50 and can be ordered from the National Technical Information Service at (703) 487-4650. ■

For answers to your questions

Physicians who have questions or concerns about CLIA inspections may call IDPH inspectors at (217) 782-6747 or (312) 793-4640. Doctors may also call ISMS' department of medical services at (312) 782-1654 or (800) 782-ISMS. ■

Practice parameters

(Continued from page 1)

als and one consumer, he said.

According to Dr. Clinton, the AHCPR guidelines differ from those developed by other groups, because panel members represent more than one specialty. The physicians involved are generalists and specialists, in practice and in academia. In addition, they are geographically diverse, "so that we are not just getting an East Coast perspective." Physicians make up the majority of the 15-member panels, he noted.

"We're talking about medical practice, so who else could write [the guidelines] besides clinicians?" Dr. Clinton asked. "It wouldn't be done by plumbers or hospital administrators. These are not financing documents. They are not the organization of medical care. These are clinical issues; they [address] how you manage the clinical care of a particular condition."

THE FIRST AHCPR parameter appeared in March 1992 with the publication of a pain management guideline. Since then, several others have been published and distributed, including guidelines on urinary incontinence, depression management, and sickle cell disease. Each publication includes a complete physician clinical practice guideline, a quick reference guide and a patient brochure.

AHCPR updates the guidelines when the individual panels find that sufficient new information exists to warrant a revision, Dr. Clinton said. More often, a revision might involve a simple clarification.

The agency has received more than 6 million guideline requests from physicians and patients, said Dr. Clinton. "I

know there is a copy in every hospital in America. That doesn't mean they are in every physician's hand."

AHCPR staff track guideline requests to learn physicians' specific usage plans and interests, he explained. "We have a news clipping service to see who is using them and who might be citing them."

"I view [the AHCPR guidelines] as a value to physicians, particularly as we move toward managed care," said John F. Schneider, MD, an ISMS Third District trustee. Dr. Schneider said he favors

We're talking about medical practice, so who else could write the guidelines besides clinicians? It wouldn't be done by plumbers or hospital administrators.

using the guidelines as educational tools to improve the practice of medicine. However, he noted that physicians and groups should adapt the guidelines to their practices. "This should not be cookbook medicine. Guidelines are like a basic recipe. [They] should be modified to taste, with extra ingredients added."

THE PARAMETERS focus on conditions that are most common, are most expensive to the nation, result in widely varying treatments and are significant to Medicare, noted Dr. Clinton. "That's the first set

of review criteria we go through." The agency also meets with various professional groups to ensure that the guidelines are widely applicable rather than narrowly defined for one particular specialty group, he added.

Dr. Clinton does not oppose the development of parameters by other medical organizations, including specialty societies. "[Physicians] certainly can't get all of their guidelines out of the federal government. We have a very modest budget. Specialty societies do guidelines, and some of them do them very well. Those would include the American College of Cardiology and the American College of Physicians. Some of them don't do them well at all. It is an expensive, complex, scientifically vigorous process."

Dr. Clinton is wary of unclear guideline development processes, though. He said there may be reason for concern about the recent practice guidelines imposed by Blue Cross and Blue Shield of Illinois. "If you heard that Sony had suddenly put a car on the market, you'd say, 'I didn't know Sony was making cars.' We're all a little surprised."

Although Florida law stipulates that physicians should follow the AHCPR guidelines, Dr. Clinton said he does not expect other states to follow suit. Instead, he said he believes the trend is moving toward guideline use or modification by large managed care organizations. Groups like PROs are already working with the agency to translate the guidelines into medical review criteria. Modification of the guidelines by other groups is acceptable as long as the level of science is maintained, Dr. Clinton added. ■

Gubernatorial race

(Continued from page 3)

ble model for implementing managed care projects throughout the state. She said she would also like to see expanded use of allied health professionals.

Edgar said he considers the Healthy Moms/Healthy Kids program – which was designed to improve access and quality of health care services for Medicaid-eligible pregnant women and children – one of the major health care and public health achievements during his first term. "We are still in the very early stages of this program. However, I am confident that today's investment will yield savings tomorrow in terms of preventing major health problems and by helping more than 500,000 poverty-stricken mothers and children establish regular relationships with physicians."

Edgar also included among his achievements the approval this year of an additional \$2 million for rural health programs, the doubling of general revenue funds for Illinois Department of Public Health HIV and AIDS services and the creation of the Center for Minority Health.

Gierach said his campaign will focus primarily on drug policy reform. If drug addicts were allowed to receive prescriptions for their addictions, crime in Cook County could be cut in half, Gierach claimed.

Gun control is another campaign issue gaining momentum. Phelan recently instituted a ban on assault weapons in Cook County, and last month, Edgar announced his support for a statewide ban on assault weapons. Edgar and Phelan also support other gun control measures to limit the availability of firearms. ■

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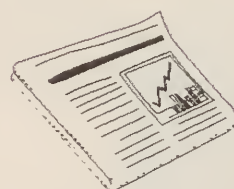
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Session III James Gustafson, M.D.	The Essentials of Brief Psychotherapy for Families, Couples and Individuals

August 1-5

Session IV Glen O. Gabbard, M.D.	Psychotherapeutic Strategies with Borderline Patients
Session V Diane Adile Kirschner, Ph.D., & Sam Kirschner, Ph.D.	Treating Survivors of Incest and abuse
Session VI Mariellen Fischer, Ph.D., Thomas A. Hammeke, Ph.D., Robert F. Newby, Ph.D., Steve M. Rao, Ph.D., & Sara J. Swanson, Ph.D.	Advance Topics in Neuropsychological Assessment and Treatment

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Session VII John H. Greist, M.D., James W. Jefferson, M.D., & David J. Katzelnick, M.D.	Psychopharmacology Consultations
Session VIII Jeffrey A. Kelly, Ph.D., David G. Ostrow, M.D., Ph.D., & Kathleen J. Sikkema, Ph.D.	AIDS/HIV Prevention, Therapy, and Mental Health Consultation Issues

For more information:

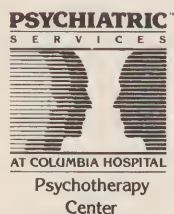
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Edgar

(Continued from page 1)

on assault weapons.

Regarding health system reform, the governor said Illinois cannot afford to wait until the debate in Washington ends before acting. Edgar said he will propose legislation this year that assures portable insurance coverage and allows small employers to boost their market power by forming purchasing pools to obtain insurance for their employees. He urged the General Assembly to act on such legislation this spring.

"Even though federal law provides access to post-employment continuation of our coverage, those policies are expensive, and for those who have lost their jobs, the cost is prohibitive," Edgar said. "I want the average Illinois worker, currently insured, to have the peace of mind that he or she will continue to have adequate and affordable health care coverage if he or she changes jobs or becomes unemployed."

The employer pool proposal would "significantly boost [small employers'] purchasing power and ability to afford coverage for their employees," Edgar said.

Voicing his commitment to ensuring fair treatment for workers and competitive costs for business, Edgar called for an administrative overhaul of the state workers' compensation system. In

Making society safe again is a challenge we must all accept today, before it is too late for our children and for all of us.

November 1993, Edgar convened a 14-member task force charged with developing recommendations for reforming the system.

Addressing violent crime in Illinois, Edgar announced his endorsement of a statewide ban on assault weapons. He devoted a significant portion of the election-year speech to his crime- and violence-reduction efforts. In the last three years, the legislature passed and the governor signed legislation extending the death penalty to drug kingpins and toughening penalties for drive-by shootings and other gang-related crimes, he noted.

"Illinois' violent crime rate actually declined by 5 percent in 1992, according to the state police, but we should take absolutely no consolation from those statistics. Our streets are still too violent.

"Some individuals should not have the right to possess firearms, and there are some weapons that no one should have the right to own," Edgar continued. "These assault weapons have become the weapon of choice among too many of our youth, replacing the handgun as the weapon of murder and mayhem in too many of our neighborhoods. Making society safe again is a challenge we must all accept today, before it is too late for our children and for all of us." ■

AIDS program

(Continued from page 1)

caid, and their incomes fall below 200 percent of the federal poverty level.

Patients referred by the department are often asymptomatic, in which case physicians perform a CD4+ cell count and continue to monitor the patient periodically, Gordon said. Other patients require more extensive care. Patients who must be hospitalized are admitted to Cook County Hospital through a special agreement with CCDPH. Once patients are admitted, the treating physicians participating in the program are no longer responsible for delivering patients' care.

Under the program, physicians are reimbursed for all office visits and laboratory tests, and medications are provided through the Illinois Department of Public Health's AIDS Drug Reimbursement Program, Gordon said.

Currently, some Illinois physicians are treating HIV patients and absorbing the costs, Gordon said. But if they join the program, they can be paid for services they had been performing pro bono, she explained.

Gordon added that some physicians may be reluctant to join the program because they fear they will be inundated with referrals. "We send a couple of patients to each doctor. They can always refuse patient referrals and can always withdraw from the program. We only ask that they give us two weeks' notice."

"I truly believe that physicians should accept HIV patients like any other patient," said B. Ramakrishna, MD, a program participant and infectious disease specialist in the southwest suburbs. Of his involvement in the program, Dr. Ramakrishna said his staff keeps the records of which patients are referred by CCDPH. "I just treat everyone as they come. I don't know who is who. But I tell my office [staff] I can take only so many people."

CCDPH is seeking primary care physicians and infectious disease specialists, Gordon said, but added that more primary care doctors are being sought because many physicians specializing in infectious disease treatment are inundated with AIDS patients.

There are several program benefits for physicians, including access to a 24-hour HIV consultation hot line operated by Cook County Hospital, Gordon said. Doctors may also choose to receive training in the treatment of HIV at the Midwest AIDS Training and Education Center of the University of Illinois at Chicago. In addition, MATEC provides periodic updates on the treatment of AIDS. "When the number of AIDS patients grows, participating physicians will be up on the new treatment," Gordon said.

In November, the department received about \$190,000 to cover treatment costs for approximately 30 patients, Gordon said, adding that CCDPH hopes to refer and fund the treatment of all eligible HIV-infected patients regardless of the number. "The program is designed to help people who fall through the cracks. For every reported AIDS case, there are an estimated eight to 10 cases of HIV infection that are unreported.

"If we don't spend [the grant], we won't get it again," Gordon continued. "We have to show that we have a network of physicians in place." ■

Heart association awards research grants

[CHICAGO] The American Heart Association of Metropolitan Chicago has allocated \$850,000 in public contributions to encourage young scientists to pursue cardiovascular research. In fiscal 1994, the funds will be used to support 37 Chicago-area research projects studying the cause, prevention, treatment or control of cardiovascular disease, said Liz Horan, AHA-MC spokesperson.

"It is through research that we have a better understanding of the causes of heart disease and ways to treat and pre-

vent it," said AHA-MC President Lawrence L. Michaelis, MD, announcing the awards. "The Chicago area has a wealth of scientific talent," he said, noting that applicants and peer review committee members, who evaluate grant applications, represent the major medical institutions in the area.

The grants, awarded in amounts up to \$25,000, are intended to cover experiment costs. Junior fellowships are awarded to new MDs, DOs and PhDs and provide salary support up to \$20,000. Senior fellowships of up to \$27,500 are awarded to researchers who are able to conduct independent research but have less than six years of experience. ■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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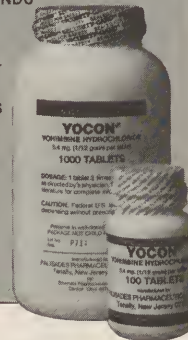
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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Illinois Medicine

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Everyone's
talking about
reform

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John McNulty



WEARING SPECIAL GLASSES, participants at a Jan. 27 neuroscience conference at the University of Illinois at Chicago observe cerebral aneurysm surgery on monitors in 3-D video.

Planning board releases economic credentialing study

STAFF PRIVILEGES: A General Assembly-mandated inquiry determines that hospitals statewide use economic criteria. By Anna Chapman

[SPRINGFIELD] The study is in. Illinois hospitals are practicing economic credentialing, according to the Illinois Health Facilities Planning Board. But physicians and hospital administrators define economic credentialing differently, the board said in a report to the legislature released Jan. 1.

A Senate resolution that passed last July called for the board to study economic credentialing practices in Illinois hospitals, ambulatory treatment centers and HMOs. ISMS supported the resolution in compliance with Board of Trustees and House of Delegates directives

calling for immediate action to address economic credentialing and due process, and to protect the right of individual physicians to medical staff privileges based on the delivery of quality care.

"Economic credentialing does exist and has the potential to jeopardize quality of care," said ISMS President Arthur R. Traugott, MD. "We should be seeking the best physicians, not the physicians who can generate the most money. It is critical that we identify how economic credentialing occurs and then discuss remedies."

"What the planning board
(Continued on page 12)

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Antitrust reform tops agenda at DePaul forum

COMPETITION: Attorneys discuss antitrust relief for health care providers. By Gina Kimmey

[CHICAGO] A competitive marketplace that ensures a low-cost, high-quality health care system isn't possible without some level of antitrust relief to encourage integration and collaboration, said speakers at a Feb. 3 symposium sponsored by the *DePaul Law Review* in Chicago. Although the speakers expressed different opinions about the degree of relief needed, they agreed that physicians' autonomy and decision-making power must be protected.

The AMA believes physicians need antitrust relief that allows them to speak collectively and ensure quality care for their patients, said Edward Hirshfeld, AMA associate general counsel. "Physicians direct most health care, and therefore, they are the most knowledgeable about where the efficiencies can be achieved. Who is better than the physician to figure out which care is necessary and which is not, and what resources are really needed to care for the patient? Because physicians are patient-oriented, they are the most likely to insist on precision, performance standards, practice guidelines and protocols."

Last month, the AMA launched a grass-roots campaign to lobby Congress to include antitrust relief in the final health care reform legislation, Hirshfeld said.



Hirshfeld

Some antitrust enforcement is necessary to prevent such negative effects of market power as escalating costs and limited alternatives, said Janet L. McDavid, a private antitrust attorney and member of the American Bar Association's Section of Antitrust Law. However, she said antitrust reforms are a critical factor in creating a market that allows consumers to be cost- and quality-conscious.

The antitrust reforms proposed last fall by the Clinton administration do not go far enough, because they fail to address the type of mergers already occurring in the health care industry, McDavid said. The administration's plan creates a situation that could adversely affect physicians, she said. "The Clinton plan essentially proposes a single alliance for each geographic area, which makes it extremely difficult for even large employers to opt out. So you will have a single buyer of health care services. The consequence may be that physicians are forced to contract with these organizations regardless of the prices and terms they are being offered."

In addition to cutting administrative costs and instituting insurance reforms, an effective reform plan must allow for competitive provider markets that can stimulate efficiency and innovation, McDavid said. This means that multiple provider groups — ranging from HMOs and PPOs to traditional fee-for-service arrangements — would compete to provide the best health care at

(Continued on page 14)

ISMS BEHIND THE SCENES

SURVEY PROVIDES ILLINOIS PHYSICIAN DATA

A recent socioeconomic survey of Illinois physicians will help ISMS develop programs and services to assist members with the transition into health system reform. The results also establish a benchmark for comparing reform's future impact on physicians. Conducted for ISMS by the Coldwater Corp., the survey was mailed last fall to 22,603 practicing Illinois physicians to learn their reactions to changes in the medical marketplace.

The survey is part of a statewide ISMS campaign called the Medical Leadership Initiative. The goals of MLI are to gather information about ISMS member needs and priorities as a basis for developing services; to inform members about the reform debate, its possible consequences on their practices and their future options; and to help members make decisions about their practices.

(Continued on page 15)

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Task force focuses on access, insurance

[SPRINGFIELD] Following his January State of the State address, Gov. Jim Edgar directed the Illinois Health Care Reform Task Force to recommend ways to expand access and implement insurance reforms.

"I believe this task force can provide solid guidance on how we can make adequate and affordable health insurance available to Illinoisans who are between jobs and help more small businesses provide coverage for their employees," Edgar said in a Jan. 19 letter to the new task force chairman Phil O'Connor.

In the letter, Edgar asked the group to develop draft legislation by April 1 including provisions to make health insurance portable in Illinois. In addition, Edgar requested that the task force explore ways to create business insurance cooperatives or alliances that would enable small businesses to purchase affordable health insurance for their employees.

"Several states have passed or are considering legislation that establishes voluntary purchasing cooperatives for small employers," Edgar said. "These states include California, Texas, Florida,

North Carolina and Ohio. As a starting point, the task force should examine the laws of other states and bring together the features of those laws that enhance and improve the existing insurance market for small employers in Illinois."

Regarding the need for portable health insurance, Edgar said that unemployed workers face dramatic increases in health insurance costs at a time when their incomes have decreased. Once they are working again, some people may be ineligible for coverage provided by their employer because of pre-existing conditions, the governor said.

To provide paid-up post-employment coverage, Edgar suggested that the task force consider developing a pay-as-you-go plan for workers, who could opt to contribute to the plan while they were employed. The governor also suggested offering guaranteed post-employment coverage by creating catastrophic insurance plans with reduced benefits and substantially reduced costs.

Edgar formed the task force in 1992, directing the group to suggest alternative funding mechanisms for the state Medicaid program. The panel of health care experts from public and private sectors recommended that Illinois continue the Medicaid assessment program with modifications. ■

SIU researcher receives alternative medicine grant

[SPRINGFIELD] Bala Manyam, MD, a Southern Illinois University neurologist, received a \$29,965 grant from the National Institutes of Health Office of Alternative Medicine to study the effect of herbal medicine on Parkinson's disease. The one-year grant is one of the first to be awarded by NIH's alternative medicine office, which opened in 1991 to investigate nontraditional medical practices and evaluate promising therapies. Dr. Manyam's grant is the office's only award to study Parkinson's. To date, the office has awarded 30 alternative medicine grants.

Dr. Manyam, professor of neurology and director of SIU's Parkinson's disease and movement disorders clinic, is studying the therapeutic value of mucuna puritans, an herbal medicine derived from a bean grown in India. He began investigating a natural remedy for Parkinson's several years ago, according to SIU officials. In addition to the NIH grant, he received a three-year \$217,000 grant from Zandu Pharmaceutical Works Ltd. of Bombay, India.

"There has been enormous competition for grants of this type from NIH's Office of Alternative Medicine - 462 applications were submitted, the highest number in the history of NIH for any one announcement. So I was very pleased when the award was received," Dr. Manyam said.

A native of India, Dr. Manyam said he is familiar with Ayurveda, the country's system of herbal medicine, and decided to base his research on some of these ancient remedies. Ayurveda is the world's oldest system of medicine, dating back nearly 6,500 years.

"Ayurveda contains several herbal treatments for diseases for which Western-style medicine has either no drug or has drugs that are too toxic or too expensive," Dr. Manyam explained.

"Claims for the effectiveness of these drugs cannot be taken for granted to be correct, nor can they be ignored. We must evaluate them in light of modern scientific methods, using laboratory studies of their pharmacology and toxicology and controlled clinical trials in patients."

Dr. Manyam said he plans to expand his studies to include other plant products that may be useful in treating neurologic diseases for which no drug therapies currently exist. ■



Matt Ferguson

CAROLE DOUGLAS (left) and Chuck Willis participate in a skiing clinic for the disabled held Jan. 29-30 at the Villa Olivia ski facility in Bartlett. The clinic featured conditioning exercises, equipment evaluation and techniques for cross-country and downhill skiing. The two-day event was sponsored by Marianjoy Rehabilitation Hospital and Clinics of Wheaton and the Western DuPage Special Recreation Association.

New clinical standards for mammography set

[WASHINGTON] In December, the U.S. Department of Health and Human Services announced new quality control measures and a certification system for medical facilities that perform and interpret mammograms. The regulations, published by the U.S. Food and Drug Administration, affect more than 10,000 testing facilities nationwide. They require facilities to obtain FDA certification by Oct 1; facilities that are not certified by that date will be operating illegally, according to HHS.

The new rules cover equipment, personnel and practices at mammography facilities. To achieve accreditation, facilities must implement quality assurance programs and monitor the radiation levels of mammography units. All personnel performing mammograms and physicians interpreting mammograms must be appropriately certified or licensed. In addition, mammography and other patient records must be retained for five years. Under the rules, certified facilities

will undergo annual inspections by federal or state surveyors working under FDA contract.

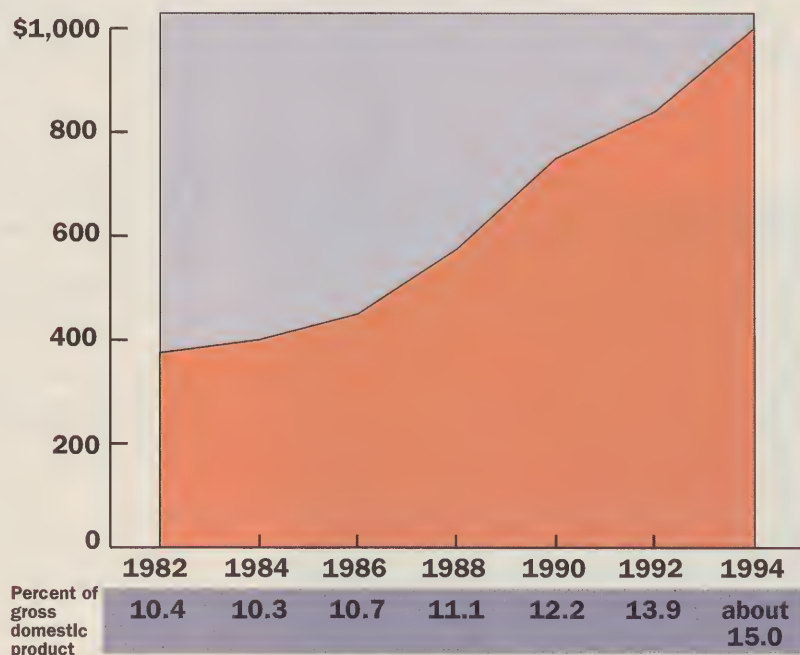
Currently, nearly 60 percent of all mammography facilities comply with standards set by the American College of Radiology, according to HHS. These standards are "substantially in compliance" with the FDA's new rules, HHS officials said, adding that the college should qualify as an FDA accrediting body with minor modifications to its standards. Some state agencies could also qualify for accreditation with little modification, said HHS.

Accrediting bodies are required to conduct annual on-site visits of mammography facilities to verify compliance with FDA standards and assess the quality of the mammograms performed there, according to the final rules. In addition, accrediting organizations must review clinical images from each facility at least once every three years and are responsible for investigating any complaints within 90 days of receipt. They must maintain their records for three years. The FDA will investigate any denial, suspension or revocation of a mammography facility's accreditation. In addition, the FDA will evaluate the accrediting entities by reinspecting some of the facilities and checking a sampling of the clinical image reviews. ■

PHYSICIAN FACTS

Health spending reaches \$1 trillion

Spending on U.S. health care in billions of dollars.
Figures for 1992-94 are U.S. Department of Commerce estimates.



Source: Department of Health and Human Services, Department of Commerce

Correction

The announcement "ISMS, Exchange annual meetings set for April," published in the Feb. 11 issue of *Illinois Medicine*, incorrectly stated that any Society member may testify on the floor of the House of Delegates. Only reference committees can accept testimony from all members. Debate before the House is limited to delegates only. ■

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Subcommittee reviews Illinois' needs and resources

REFORM: ISMS suggests several possibilities for improving access and containing costs. By Anna Chapman

[CHICAGO] Illinois seems ready for independent action on health system reform, but as yet there has been little consensus on how to proceed, according to Rep. David Phelps (D-Eldorado), chairman of the Subcommittee on Illinois' Response to National Health Reform. The subcommittee held its second public hearing Feb. 8 in Chicago.

The subcommittee, which is composed of members of the Illinois House of Representatives' Health Care and Human Services Committee, will use information gathered at the hearings to develop a General Assembly action plan to influence national reform, Phelps said.

ISMS President Arthur R. Traugott, MD, submitted written testimony focusing on physicians' ideas for making health coverage more available and affordable in Illinois. He also urged state lawmakers to consider measures that would improve access in rural Illinois but would not diminish the quality of care in these areas.

"Illinois law today requires that human conditions and ailments be diagnosed and treatments for them prescribed by a physician," Dr. Traugott wrote. "Some other practitioners without the physician's level of training and experience will undoubtedly ask you to abandon this standard. But there is no evidence that allowing these other professionals to practice independently – without the sensible requirement of physician supervision – will lessen costs or improve access."

Outlining areas for possible legislative action, Dr. Traugott told the subcommittee that the more decisions Illinoisans can make for themselves, the stronger the health care system will be.

Dr. Traugott first stressed that health insurance should be portable. He suggested two options to ensure portability: a contributory coverage plan to provide employed workers with paid-up coverage between jobs and a plan that would offer catastrophic coverage between jobs, including essential benefits at greatly reduced cost.

He also urged the subcommittee to consider reforming the health insurance market by creating pools or cooperative purchasing arrangements for small businesses. "Many Illinoisans work for small businesses, and many small businesses are priced out of the health insurance market." In addition, Dr. Traugott suggested moving toward community rating of health insurance premiums and limiting pre-existing condition exclusions.

Recommending that Illinois establish a \$250,000 cap on noneconomic damages in medical malpractice lawsuits, Dr. Traugott said the current legal system creates an environment for higher malpractice insurance premiums, defensive medicine costs and legal defense costs. "Without meaningful tort reform, it is all but impossible to imagine that health care reform can succeed."

Dr. Traugott also noted Illinois physicians' national efforts to remove antitrust barriers limiting their ability to negotiate collectively on behalf of patients.

Others submitting testimony to the

subcommittee included representatives from organizations specializing in state health policy and Bernard J. Turnock, MD, immediate-past president of the Illinois Public Health Association.

Kala Ladenheim of the Intergovernmental Health Policy Project at George Washington University presented an

overview of reform strategies undertaken by other states. States that have taken their first steps toward enacting legislation have concluded that there can be no universal access to care without some form of cost containment, she said. However, she stressed that Illinois should "take its own temperature" and not look to other states for reform guidance.

POLICY-MAKERS MUST be dedicated to state-level reform, said Debra Lipson, associate director of the Alpha Center, an affiliate of the Robert Wood Johnson Foundation, which helps states with their health care policy. "It is very important that both the governor and the legisla-

ture work together, that they be vested in the process in the beginning, in the middle and the end. This issue is so complicated, so difficult, so costly that without everybody's commitment, it's simply going to be almost impossible to make much progress."

Dr. Turnock said that the movement toward reform represents a "major threat to the public health services we have today." He added that he fears the reform debate has shifted from its true focus of improving the health of Americans. The role of public health needs to be clearly defined and funded, but the front-running reform plans do not include such provisions, he said. ■

Blue Cross Blue Shield REPORT FOR Illinois Physicians

C-SECTION RATES

Introduction -- Blue Cross Blue Shield of Illinois (BCBSI) has had an ongoing Quality Improvement Program for the past few years to reduce the state-wide C-Section rate. The Chairperson of the Department of Obstetrics and Gynecology of Illinois' hospitals with over 60 deliveries per year on BCBSI enrollees have been informed of their hospitals C-Section rate, and BCBSI has asked for information which might be shared with others, as to how that OB/Gyn Department monitors and controls C-Sections. The following is a compilation of these "best practices" which have been suggested and instituted by the OB/Gyn Departments themselves.

SUMMARY OF HOSPITAL ACTIONS TO LOWER C-SECTION RATES ("BEST PRACTICES")

A. Efforts to Reduce Repeat C-Sections (Encourage VBAC)

1. Adopt formal VBAC guidelines - either those of the ACOG, or locally developed ones which are often more aggressive (more liberal inclusion criteria).
2. Precertification requirement for all elective repeat C-Sections.
3. Retrospective review of all records of any repeat C-Sections at a regular conference or by Department Chair; discuss cases with attending physicians.
4. Implement patient education programs: • VBAC classes for all potentially eligible women. • "VBAC Night" conference in which staff physicians address patients. • Patient information brochures distributed via physician offices. • VBAC resource library. • VBAC counselor (RN) hired by hospital. • Any woman having a primary C-Section has a post-partum teaching visit on VBAC (for the future) before discharge.
5. Physician educational sessions - by leading experts, on VBAC and active management of labor. Also for labor and delivery RN's.
6. Use of midwives.

B. Provide Educational Feedback on Practice Profiles

1. Active peer review program - retrospective case review of all C-Sections, regular (weekly) Department meeting to discuss with attending physicians. • Some only review cases done for certain indications or by practitioners with rates above an agreed threshold.
2. OB data reports given regularly (quarterly) to all Department physicians - includes ALOS, primary and repeat C-Section rate, VBAC success rate. Such statistics kept and tracked by the Department; reviewed by Chair or designated committee.
3. Aggregate report on Department's performance on stated indicators given monthly to all physicians.
4. Some Departments have full disclosure - each physician's statistics released to whole Department.
5. Some Departments have acquired formal commercial software to generate, track these reports.
6. Regular distribution of information on C-Section rates at other area hospitals.
7. Mandatory second opinion on all but truly emergent C-Sections. • Generally seen as problematic. Puts consultants in a difficult position, and likely adds little if other peer review activities in place.

C. Other Actions

1. Attempt at external cephalic version encouraged for breech presentations.
2. Assure 24 hour inhouse OB call - to eliminate the temptation to "get the delivery over with and go home."

(Issue: 02/25/94 - ALW)

Statehouse races



With election day less than three weeks away, *Illinois Medicine* wraps up its pre-election coverage of the 1994 primaries in this issue. The following roundup of selected races was designed to provide physicians with the health-care-related positions of candi-

dates running for the House of Representatives. The races are grouped by district, and the incumbents are marked with an asterisk. To determine your congressional and General Assembly districts, check your voter registration card or call the local board of elections.

Watch future issues of *Illinois Medicine* for coverage of the primary results and the fall general elections.

YOCON® YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

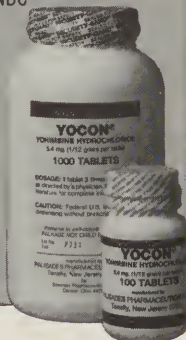
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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70th district

David A. Wirsing* (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: One change we do not need is for government to run our entire health care system. I would like to see Medicaid recipients given an incentive to get primary care from primary care physicians rather than from emergency rooms. We need to institute checks in the system to weed out fraud and punish those who abuse it. We should also look at ways of reducing paperwork and streamlining the offices that process that paperwork.

71st district

Deb Toppert (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, sin taxes

Clinton plan: Oppose

Other plans supported: AMA's Health Access America

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Tort reform, universal access with comprehensive coverage including preventive services, insurance reforms such as community rating and elimination of pre-existing condition exclusions, and increased patient responsibility for health-costly habits like smoking and drinking

Mike Boland (D)

System I recommend: I am open-minded. I favor single payer, but I am interested in any system that improves access and cuts paperwork.

Funding sources I support: Combination of government funding and employer-paid benefits, in addition to savings achieved through universal access that reduces emergency room use, elimination of no-bid contracts by state government, enactment of term limits to decrease legislative and executive pensions, and switching to a unicameral legislature

Clinton plan: Support, as it may be the only alternative to the current mess, but I would prefer a better plan. Could we develop a plan with the best from Clinton, Cooper-Grandy, Hawaii's system and single payer?

\$250,000 cap on noneconomic damages: No position

Other reform suggestions: Simplify paperwork and cut costs to free doctors' time for medicine, emphasize preventive care and health education, eliminate pre-existing condition clauses in insurance, and reward businesses that promote healthy lifestyles by providing employee gyms, smoking-cessation programs, alcohol and drug abuse programs and AIDS education

Wayne Neal (D)

System I recommend: I need more information, and I am currently meeting with groups on this subject.

Funding sources I support: Combination

of government funding and employer-paid benefits and individual contributions

Clinton plan: Uncertain. I'm not sure of all the details yet.

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Oppose, but would be open for discussion

Other reform suggestions: Insurance reforms such as community rating and elimination of pre-existing condition clauses, insurance coverage for preventive health programs, universal coverage, reasonable costs for all parties involved and use of pension plans, IRAs and 401(k)s to make tax-free insurance purchases

Marlys C. Vermeire (D)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Support

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Increased funding, limitations on office visits when people do not really need to see a doctor, preventive health programs, insurance reforms such as community rating and elimination of pre-existing condition clauses, and malpractice reform

81st district

Judy Biggert* (R)

System I recommend: Public-private partnership

Funding sources I support: Cost reduction and reforms

Clinton plan: Oppose

Other plans supported: Undecided

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: As suggested by Gov. Edgar, administrative cuts, tax credits and resource pooling to provide coverage to small businesses. Significant attention must be dedicated to controlling waste and fraud in our current system. We need to find a way to provide cost-effective service and eliminate the use of unnecessary services such as emergency room visits for nonemergency procedures. We must implement checks in the system to identify and penalize fraudulent use of Medicaid funds by patients and doctors.

James P. McCarthy (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, sin taxes and individual health insurance

Clinton plan: Oppose

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: Despite common criticisms, we have the best medical system in the world. It seems that its critics would rather trash the entire system than make whatever minor changes are necessary. Since the rich and the poor have access to health care, the main problem is insuring those in lower-paying jobs or those with some pre-existing condition that currently makes them uninsurable. In addition, as an insurance defense attorney, I am very much in favor of ending ridiculously high jury verdicts.

82nd district

Kathleen A. Moesle Bazon (R)**System I recommend:** Public-private partnership**Funding sources I support:** Combination of government, employers and insurance companies**Clinton plan:** Oppose**Other plans supported:** None stated**\$250,000 cap on noneconomic damages:** I'm not sure whether \$250,000 is the proper amount.**Other reform suggestions:** I support eliminating pre-existing condition clauses, retaining existing health care programs used by companies or individuals, and setting up pools for the uninsured that are funded by government and insurance companies. In addition, the focus must be on primary care and preventive health care, requiring individuals to see their doctors regularly to keep their coverage.**Jim Meyer*** (R)**System I recommend:** Public-private partnership**Funding sources I support:** Combination of government funding and employer-paid benefits, sin taxes**Clinton plan:** Oppose**Other plans supported:** I think there are good components in the Cooper proposal and the Senate and House Republican task force proposals.**\$250,000 cap on noneconomic damages:** Favor**Other reform suggestions:** Tort reform. We must get the lawyers out of doctors' offices. The cost of malpractice insurance and defensive diagnostic tests that doctors are forced to perform push health care costs through the roof. We should also allow employees and individuals to deduct 100 percent of the cost of qualified health plans, enable individuals to set up medical IRAs, provide access to all Illinois residents and establish insurance reforms, including portability and elimination of pre-existing condition limitations.

90th district

Stephan A. Mesner (R)**System I recommend:** Public-private partnership**Funding sources I support:** Employer mandates, sin taxes and a combination of government funding and employer-paid benefits**Clinton plan:** Oppose**Other plans supported:** None stated**\$250,000 cap on noneconomic damages:** Favor**Other reform suggestions:** First, we need to control the cost of health care. We must also get a better understanding of why costs have skyrocketed. There should be some standards on costs for certain services. In addition, more health care clinics should be established to provide nonurgent care to everyone at more cost-effective rates.**John W. Turner** (R)**System I recommend:** Public-private partnership**Funding sources I support:** Combination of government funding and employer-paid benefits**Clinton plan:** Oppose**Other plans supported:** Elements I support are included in two plans — the Nickles Consumer Choice Plan and the Gramm

Comprehensive Family Health Access and Savings Act.

\$250,000 cap on noneconomic damages: I haven't decided yet at what dollar level caps should be set.**Other reform suggestions:** I advocate restructuring the tax code and reforming the insurance industry to provide access to insurance for everyone, portability and elimination of pre-existing condition clauses. In addition, our Medicaid system is a mess, in part because of a bloated bureaucracy. Health care providers are inundated with seemingly endless forms. The payment system must be simplified and streamlined. Medicaid recipients must also be given some minimal

responsibilities to appreciate the value of the benefits they receive and to share in the cost of administering the program.

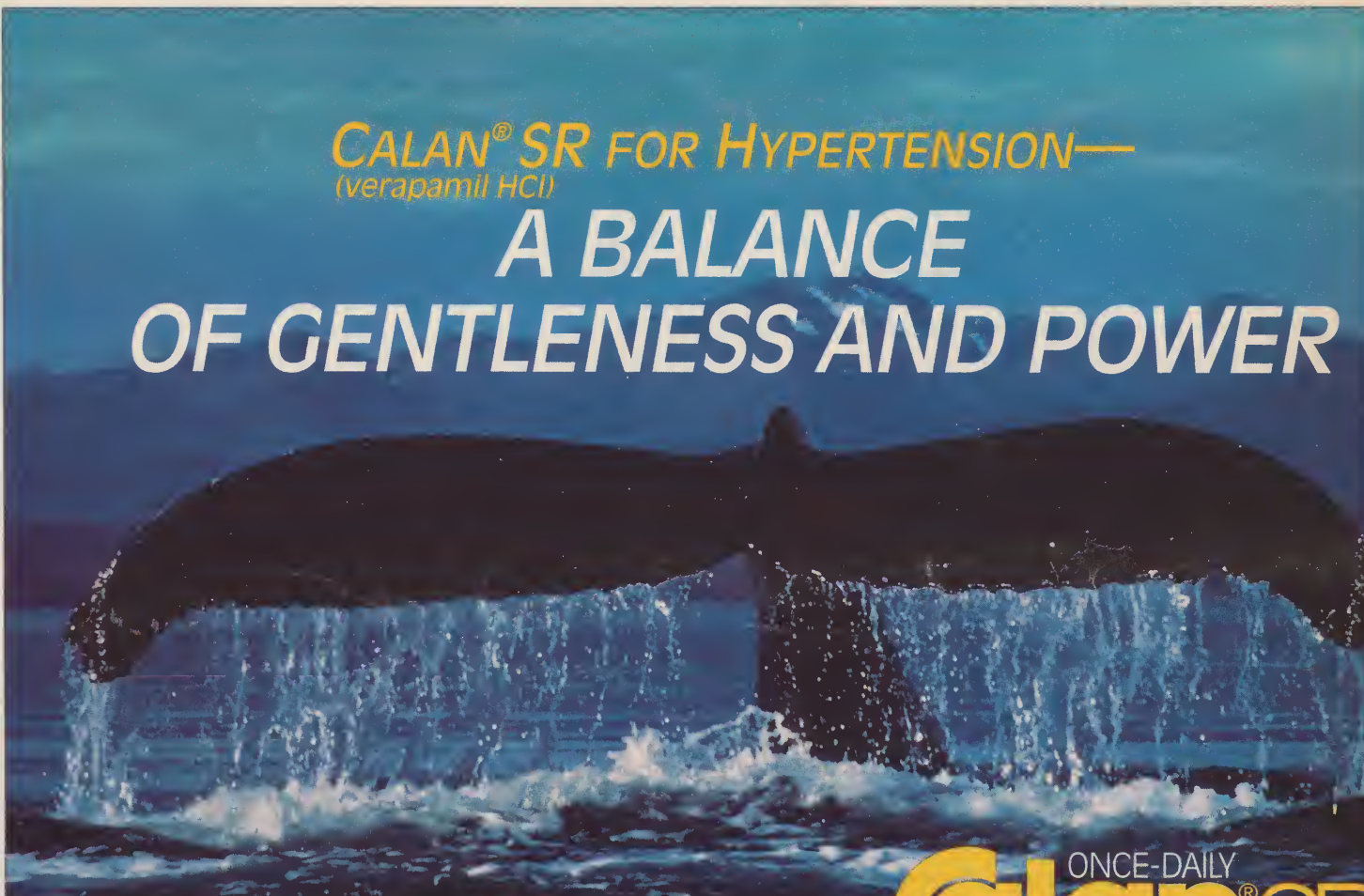
100th district

Gwenn Klingler (R)**System I recommend:** Public-private partnership with provisions to address the uninsured and provide catastrophic coverage**Funding sources I support:** Sin taxes and innovations devised by private insurers to make insurance more affordable, such as enabling small employers to unite to obtain larger group rates**Clinton plan:** Oppose**Other plans supported:** An alternative like the Cooper plan should be explored.**\$250,000 cap on noneconomic damages:** Favor**Other reform suggestions:** Significant tax incentives should be provided to encourage all citizens to obtain a basic health insurance plan. We should explore creative approaches such as medical IRAs, which allow individuals to set aside money for uncovered medical expenses and if the money is not used, allow them to use the funds later in life. The public aid system of providing health care needs to be overhauled as well. Hospitals, nursing

(Continued on page 14)

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The recommended starting dosage for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food. Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY
Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.
Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.
Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia, HR < 50/min (1.4%), AV block: total 1° 2° 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

Take time to vote on March 15

It's that time again – time to vote in the primaries to determine the ballot for the general elections. You may have noticed that *Illinois Medicine* has recently devoted a lot of space to the primary races. That's because voting is more crucial than ever this year. Our professional futures and our patients' futures are on the line.

Elements of health system reform are being shaped at the federal level and will eventually be implemented at the state level. In fact, the Subcommittee on Illinois' Response to National Health Reform is holding hearings to develop a General Assembly action plan to influence national reform. And Gov. Jim Edgar recently directed the Illinois Health Care Reform Task Force to focus on expanding access and instituting insurance reforms.

ISMS is actively participating in the reform debate, sponsoring town meetings across the state so that legislators, businesspeople, physicians and consumers can share their ideas. The Society has also developed patient kits that physicians can use to help educate their patients about quality of care issues. In addition, ISMS representatives are traveling statewide to talk to members about their needs and priorities related to reform.

Your ISMS elected leadership is busy testifying at hearings and speaking at town meetings to voice physicians' con-

cerns. At the federal level, the AMA and ISMS, through its Washington Presence program, are meeting with congressional leaders to keep the dialogue going. In fact, ISMS will participate in an AMA-sponsored meeting in Washington on March 8 to discuss medicine's congressional goals. Although the Society is active on many fronts, we need your involvement.

One way you can be involved is by voting. Coverage of some key Statehouse races begins on page 4 of this issue, with candidates sharing their positions on the health system they recommend, funding sources they support and tort reform. In the last two issues, we've covered more Statehouse races, as well as primaries for the gubernatorial, congressional, secretary of state, attorney general, treasurer and comptroller races. If you're not sure of where certain candidates stand on health care issues, review your Jan. 28 and Feb. 11 issues of *Illinois Medicine*. To determine your district, check your voter registration card or call your local board of elections.

ISMS can do a lot to inform legislators about your concerns, but that effort will be most effective if it's complemented by your participation. Make the time to vote on March 15. Then after the elections, follow the issues related to reform and make legislators accountable for your vote.

PRESIDENT'S LETTER

What the state should do about reform

By Arthur R. Traugott, MD



Coverage should remain with workers through periods of unemployment and follow them to future jobs.

I was recently asked to provide testimony for the Subcommittee on Illinois' Response to National Health Reform. Unfortunately, a winter storm prevented my attendance at the hearing. However, my written testimony was submitted, including the following key points.

Generally, the more decisions we Illinoisans can make for ourselves, the better the resulting health care system will be designed to meet our particular needs. One critical action state legislators should take is to make health insurance portable for employees who are between jobs. This would also affect those who would like to change jobs but are concerned about their ability to obtain future coverage. Coverage should remain with workers through periods of unemployment and follow them to future jobs – without gaps or the need to satisfy pre-existing condition clauses.

To provide portability, there are at least two options. One is a coverage plan to which employees could contribute while they were working. Then, when they needed the coverage, the premium would have already been paid. Another option would be to provide catastrophic coverage, which would offer basic benefits at greatly reduced cost during lulls between jobs.

State legislators should also consider reforming the health insurance marketplace. We should help those small businesses that would like to provide coverage for their employees but can't afford to without the risk of financial disaster. These businesses should be able to form pools or cooperative arrangements and benefit from the economies of scale that are currently available only to larger employers. Other states have already enacted such reform.

Additional insurance reforms should include a return to modified community rating to set premiums and elimination of pre-existing condition clauses. The latter is one of ISMS' top goals for health system reform, and we intend to pursue it at the state and national levels.

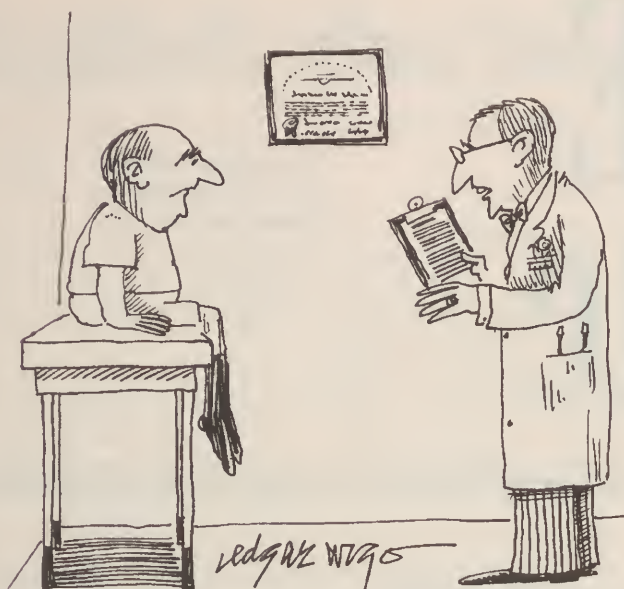
Next, the state should act on tort reform to rein in health care costs. Our legal system is out of control. This results in the ever-increasing practice of defensive medicine and its related costs. Meaningful reform would allow full recovery of economic losses and would cap noneconomic damages – such as those for “pain and suffering” – at \$250,000. Simply put, without tort reform, health system reform cannot succeed.

Illinois law currently stipulates that only physicians can diagnose and treat people's ailments, recognizing physicians' unique medical training and experience to provide those services. But some health care practitioners who lack physician qualifications may ask legislators to abandon or reduce that standard.

It's true that in our state, residents in rural and inner-city areas don't always have the same access to health care as individuals living in communities with a sufficient supply of physicians. But people in underserved areas should not have to settle for lower-quality care than other Illinoisans receive. That sacrifice just isn't necessary if we commit our efforts and resources to some other options. We can integrate the Medicaid program into a standard health insurance program that covers everyone under a guaranteed health benefits plan. We can expand communication links to hospitals, clinics and centers of medical knowledge and technology to maximize resources. And we can increase loan and incentive programs to attract physicians to underserved areas.

We will continue to fight any diminution of the quality of patient care and any economic edicts that intrude into the doctor-patient relationship. In return, we physicians recognize our responsibility to practice cost-effective medicine. In fact, we believe education on cost containment should begin in medical school.

Physicians and patients remain actively committed to doing our part in reforming the system, and we hope our state will do its part too.



"Your last annual checkup was 11 years ago."

GUEST EDITORIAL

Dear Mr. President ...

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January 13, 1994

Dear President Clinton:

Price controls produce shortages, black markets and reduced quality. This has been the universal experience in the 4,000 years that governments have tried to artificially hold prices down using regulations.

You insist that your health care plan avoids price controls. We respectfully disagree. Your plan sets the fees charged by doctors and hospitals, caps annual spending on health care, limits insurance premiums, and imposes price limitations on new and existing drugs.

In countries that have imposed these types of regulations, patients face delays of months and years for surgery, government bureaucrats decide treatment options instead of doctors or patients, and innovations in medical techniques and pharmaceuticals are dramatically reduced. Here in America, the threat of

price controls on medicines has already decreased research and development at drug companies, which will lead to reduced discoveries and the loss of life in the future.

In the 1970s, the government tried to regulate the price of a simple homogeneous product, gasoline. The result was a social and economic disaster. People were forced to waste hours waiting in lines to purchase gasoline. Long waits for surgery and other medical care will have far more serious consequences.

Caps, fee schedules and other government regulations may appear to reduce medical spending, but such gains are illusory. We will instead end up with lower-quality medical care, reduced medical innovation, and expensive new bureaucracies to monitor compliance. These controls will hurt people, and they will damage the economy. We urge you to remove price controls, in any form, from your health care plan.

The above letter was signed by 562 economists who are on staff at colleges and universities throughout the United States.

Don't forget the annual meeting

The 1994 ISMS House of Delegates Annual Meeting will convene April 22-24. This year's meeting will again be held at the Oak Brook Hills Hotel, 31st Street and Mid-west Road in Oak Brook.

The deadline for receipt of resolutions is the close of business March 22; a March 22 postmark is not sufficient. Resolutions received at ISMS offices after that date will be reviewed by the Committee on Rules and Order of Business to determine whether the House will consider them. Only delegates and voting members of the House may submit resolutions.



Resolutions should be addressed to Mr. Richard Ott, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

The ISMIE Annual Meeting is scheduled for Wednesday, April 20. It will also be held at the Oak Brook Hills Hotel. ISMIE board elections will take place during the meeting.

Informational materials and meeting packets will soon be mailed to House of Delegates members. For more information about the ISMS and ISMIE annual meetings, call (312) 782-1654 or (800) 782-ISMS ■

GUEST EDITORIAL

C'mon, is this guy a healthy choice?

By Mike Royko

Reprinted by permission: Tribune Media Services. Mike Royko is a syndicated columnist based in Chicago.

The White House has brought in a new health care czar. It is his job to pull everything together and get the Clintons' revolutionary plan turned into law.

And I have to admit that the new health plan boss — Harold M. Ickes — has perfect credentials for the job.

First of all, he is a lawyer. But of course. Just about everyone involved in rebuilding the nation's medical world are lawyers. Around the White House, especially the health care people, if you don't know how to write a writ, you are a barbarian.

It is rumored, falsely, I assume, that when a physician tried to sneak into one of the planning meetings, he was taken to the White House basement, put in chains and whipped with his own stethoscope. He was released, they say, only after promising to enroll in a law school.

And what does health czar Ickes know about health care? Besides flossing his teeth, apparently not much.

As a *New York Times* story that raved about his brilliance said: "What Mr. Ickes does not bring to his job, he acknowledges, is expertise in health care."

It quotes him as saying: "I was brought in to help talk strategy and help manage the overall process. I wasn't brought down here to be a health care expert."

Which makes perfect sense. You put someone in charge of steering a monster-sized reshaping of our nation's health care through Congress, the last thing you want to do is confuse him with details about actual health care. A bedpan is a bedpan. You see one bedpan, you've seen them all. So what else does he have to know about health care?

No, the special skills that Ickes brings to his role as the new health czar were described by a Clinton political adviser.

"Harold brings passion and excitement."

Those, of course, are qualities any sensible person would look for in a health care czar.

Or in a blind date.

But he has other qualifications that make him an ideal choice for the Clinton administration.

He was born into a prominent political family, his father a Cabinet member for Franklin D. Roosevelt.

And as one who came of age in the 1960s, he has marched to the same social drumbeats as most friends of Bill and Hillary.

He, like Clinton, was part of the anti-war movement. And he worked in the presidential campaigns of Eugene McCarthy (a loser), Ed Muskie (another loser), Morris Udall (a really spectacular loser), Ted Kennedy (a loser, but a really fun guy at the beach), Walter Mondale (a dull loser) and Jesse Jackson (a feisty loser).

Most recently, he worked for New York Mayor David Dinkins, who managed to defy all odds by running so flabby a campaign that he lost an election Beavis and Butt-head could have won.

So Ickes, as a political operative, has never been described as a king-maker. He appears to have spent most election nights sitting around with a lot of depressing people.

But it isn't whether you win or lose, or even how you play the game. It's whether you get in a big law firm, make some bucks and pick up some important friends along the way.

And Ickes became one of those fortunate people who is a Friend of Hillary and Bill.

He ran Clinton's New York primary campaign, which Clinton won. Considering the drabness of the competition, that is not one of the major political triumphs of the 20th century. But it helped Clinton stumble to his destiny as Arkansas' gift to the rest of us.

And now he is in charge of shoving the Clintons' health care package down our throats. Or from the opposite direction, if you want to think of it that way.

While he doesn't know as much about health care as the nurse on the midnight shift at your local hospital, he realizes how important this program is.

"It's probably the most important social problem, certainly in my lifetime and probably in decades. It [is] a great opportunity to work with this administration and on this program."

Absolutely right. And I wish him luck. I also offer a bit of advice. If the pressures of being the health care czar get to you, and you get sweaty and feel chest pains, dizziness, you can just ring your secretary and have her rush in one of your fellow White House lawyer health care experts.

He can thump on your stomach to get the old heart pumping again, give you mouth to ear, and you'll be as good as new.

It is rumored, falsely, I assume, that when a physician tried to sneak into one of the planning meetings, he was taken to the White House basement, put in chains and whipped with his own stethoscope.

When patients refuse blood transfusions

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ISMIE Update

ISMS urges state reform subcommittee to enact tort reform

PAGE 3

ISMIE earns high marks

Survey shows strong policyholder satisfaction with ISMIE's claims representatives and defense attorneys. By Gina Kimmey

The results are in from the first survey in a continuing series to monitor ISMIE claims service. The message was clear: If faced with another claim, most respondents would want the same individuals to handle their case.

The ongoing surveys were designed to gauge policyholders' satisfaction with ISMIE's claims process. Specifically, policyholders against whom a claim has been filed are asked to rate the service they received from ISMIE staff and defense attorneys.

"These results are terrific news for ISMIE. They illustrate the success of our Physician-First Service program," said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. "Our policyholders' satisfaction is the best measure of the company's effectiveness in meeting the needs of our physi-

cian owners. We are also very pleased with our 37-percent response rate."

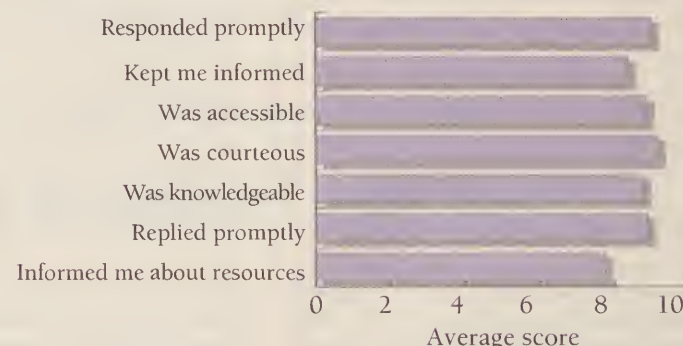
Three different questionnaires were developed to enable physicians to provide information specific to the stage of their particular claim, Dr. Jensen explained. The first questionnaire was mailed to policyholders within the first 60 days of the claim process. The second was mailed to those physicians who had been through the initial Physician Review Committee evaluation, but whose claim was still open. The third was sent to physicians whose claims were closed between July 1, 1992, and July 31, 1993. To continue assessing ISMIE performance, the same survey process will be repeated indefinitely.

The questionnaires asked policyholders to rate their overall satisfaction with the ISMIE claims analyst and defense attor-

ney assigned to their case. When rated as a team, claims analysts and attorneys received an average score of 8.6 on a scale of zero to 10. In addition, 94 percent of respondents said they would prefer to have the same claims analyst if they were faced with another claim, and 92 percent said would like the same defense attorney.

Rated separately, again on a scale of zero to 10, analysts and defense attorneys received average scores of 8.3 or higher for responding promptly to policyholders' claims and questions, keeping policyholders informed, being accessible, showing courtesy and professionalism and demonstrating knowledge. In addition, defense attorneys received average scores of 8.8 for preparing policyholders for depositions and trial testimony and preparing an aggressive defense.

Satisfaction with ISMIE representative



Source: ISMIE claims monitoring survey

"The results are proof that our efforts have paid off," Dr. Jensen said. "We now have strong data to show that ISMIE policyholders are receiving prompt, courteous and efficient service when they need it most."

The survey revealed that physicians who have been insured with ISMIE for two years or more are more satisfied with the company's service than physicians who have been insured for one year or less. These results seem to show that

the more experience physicians have with ISMIE, the more they value its performance, Dr. Jensen said.

Indemnity payments seemed to affect physicians' satisfaction with the claims process more than the number of claims they have faced. Policyholders whose claims closed with indemnity payments of less than \$100,000 or more than \$1 million indicated higher overall satisfaction with ISMIE than physicians whose cases were closed with indemnity payments between \$100,000 and \$1 million.

The only significant area for improvement is providing information to policyholders about ISMIE services, Dr. Jensen said.

Policyholders who received the first questionnaire were asked whether their claims analyst told them about ISMIE's risk management resources. According to the results, analysts received an average score of 7.7, which is lower than their scores in other areas. The rating suggests that not all physicians are receiving information about the seminars, support groups, videos and literature that might assist them during the claims process, Dr. Jensen noted.

The second and third questionnaires asked policyholders whether they had been told about ISMIE's defendant reimbursement coverage. Through this program, physicians are reimbursed for the time they spend away from their practice during their trial and while participating in depositions other than their own. Sixty percent of the respondents said their defense attorney did not inform them of this benefit, and 49 per-

(Continued on page 9)

MALPRACTICE ROUNDUP

Jurors' prejudice questioned on appeal

An Illinois appellate court ruled that three jurors did not prejudice the outcome of a trial, according to *The Malpractice Reporter*. After the trial jury found in favor of the defendant, the plaintiff argued on appeal that two jurors who made prejudicial comments during jury selection should not have been allowed to serve on the jury and that the comments of a third juror during trial should have resulted in a mistrial.

One juror had revealed that his son was undergoing treatment from a surgeon at the same clinic at which the defendant physician practiced. The plaintiff's attorney argued that "any rational juror would be legitimately concerned that a verdict against [the physician] would make subsequent treatment by the surgeon of his son more difficult."

The attorney also argued that a second juror should have been removed after he admitted that he would be hesitant to award damages for pain and suffering. However, the court ruled that the juror's comment "did not outweigh his clear expression of impartiality and his specific willingness to award damages according to the evidence heard."

Regarding the third juror, the attorney argued that a comment the juror made about the rising cost of medical malpractice insurance should have resulted in a mistrial, because the statement was "highly prejudicial and affected the jury panel." But the appeals court said the juror's single comment was insufficient to warrant a mistrial and affirmed the verdict for the defense. ■

Law firm must pay expert witness

A Pennsylvania appeals court affirmed that a law firm may not refuse to pay an expert witness whose trial testimony differed from testimony the expert presented in earlier cases. *Medical Malpractice Law & Strategy* reports that the plaintiff's attorney hired the expert after reviewing copies of her depositions from previous cases. But during cross-examination, the defense questioned the witness in an area the plaintiff's attorney had not reviewed with her before the trial. However, the subject was included in her previous depositions. Her testimony conflicted with the deposition testimony from earlier cases, which the plaintiff's attorney had reviewed. The lawyer claimed that her answers contributed to the jury's decision for the defense.

After the law firm refused to pay her, the expert sued. The firm countersued, alleging that the expert's services were inadequate. The trial court dismissed the counterclaim, and the decision was affirmed on appeal. The plaintiff also sued the expert, claiming breach of contract, negligence, gross negligence and negligent misrepresentation. That case is still pending.

According to *MMLS*, there are no guidelines establishing the duty owed by expert witnesses to those who employ them. However, a physician commenting on the case said the expert should not have been sued for changing her opinions, because "science marches on." Another physician said the expert appeared to have been "doing due diligence by keeping up with the [professional] journals" and revising her opinions accordingly. ■

When patients refuse blood transfusions

Physicians face risk management considerations when treating religious patients who refuse some treatments. By Curtis Gunter

The following article is reprinted with permission from the Louisiana Medical Mutual Insurance Co. It was published in the Jan./Feb. 1994 issue of The Letter.

The belief of some religious groups precludes its members from receiving blood transfusions. Obviously, this presents a serious problem for the physician in treating many illnesses. Members of some religious groups will not even accept an autologous transfusion, but will accept their own blood in continuous circulation such as through the process of dialysis or a heart/lung machine.

Judicial decisions about overriding a patient's refusal of blood have been fairly consistent. Although the wishes of competent adults are honored, the parent almost never has the right to deny a life-saving transfusion for a minor child. Most jurisdictions will also order a pregnant woman to be transfused against her will, to save the fetus. However, this issue is still being debated by medical ethicists and courts today.

It is important to note that many physicians have found that people with these religious beliefs are responsible and compliant patients. "Jehovah Witness followers are not challenging the medical community or trying to be difficult. This issue is only concerned with blood transfusions, which are against their religious beliefs. As long as physicians offer alternatives of non-blood management that stay in the parameter of their belief, these patients are appreciative of medical care," says Heidi Austin of the Institute of Bloodless Medicine and Surgery.

If you are faced with this difficult situation, the following are some tips to remember:

- Inform the patient of whether or not

you can comply with the patient's refusal to have a blood transfusion. If you agree to comply, draft a fully detailed informed consent form and have it reviewed by legal counsel. During the informed consent meeting, inform the patient of the risk and consequences of refusing the blood transfusion.

- Find out if your hospital has a policy on involuntary transfusions. Discuss this

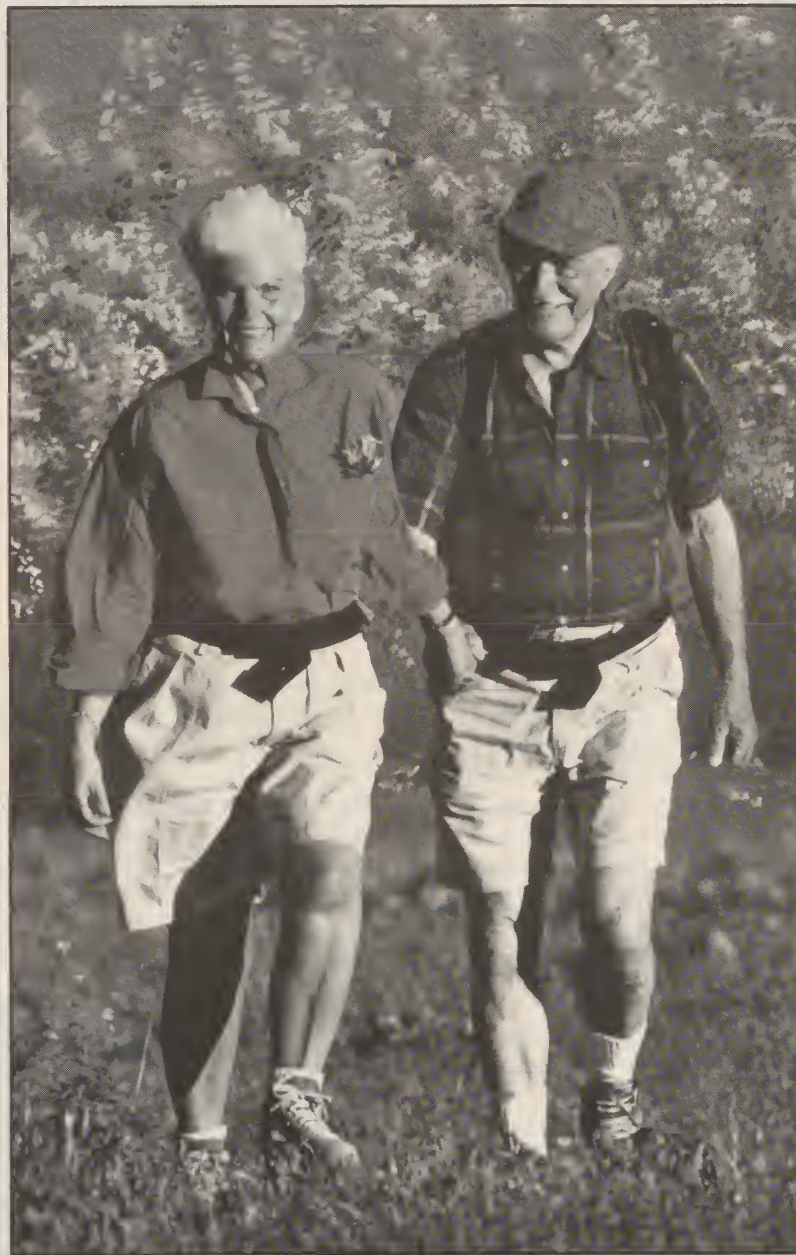
with the hospital administration, hospital ethics committee and hospital counsel.

- Discuss the case with counsel such as your hospital administrators, malpractice carrier, and state medical society attorney.

Often, when dealing with a patient with these religious beliefs, the basic issue isn't one of medicine and religious convictions, but of informed consent. As

with any other patient, problems are less likely to occur if the physician takes time to conduct an honest, open dialogue with the patient. The physician and the patient should agree on the treatment plan that will be implemented.

The Institute of Bloodless Medicine and Surgery, Coast Plaza Medical Center, Norwalk, California, Phone 800 NO-BLOOD, has a nationwide list of physicians who can often meet the needs of patients with these religious beliefs. Other institutions experienced in working with these religious groups are Hutzel Hospital in Detroit and St. Luke's Episcopal Hospital in Houston. ■



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ISMIE survey

(Continued from page 8)

cent said their claims analyst failed to tell them about it.

"We have worked hard to develop programs and policies that will make the claims process as painless as possible," Dr. Jensen said. "These services are intended to lessen the burden. We will use these findings to strengthen our efforts."

All three questionnaires also provided space for physicians to write additional comments if they indicated that the ISMIE team did a "poor job." Among the few negative experiences listed were a change of claims analyst or defense counsel during the process, a feeling of abandonment generated by a defense attorney and a perception that a physician was not kept well-informed. According to Dr. Jensen, ISMIE staff addressed any specific problems raised on questionnaires individually, by phone or letter.

"It will be difficult for the ISMIE team to improve on these scores in subsequent surveys," he said. "But ISMIE pledges to keep striving to ensure that every policyholder is 100-percent satisfied and to continue obtaining feedback from policyholders." ■

HEALTH CARE DEBATE

Everyone's talking about reform

An ISMS-sponsored town meeting in Chicago provides the setting for physicians, community leaders, business representatives and the public to exchange views.

BY GINA KIMMEY

At the first in ISMS' series of statewide town meetings on health care reform, attendees voiced their concern about the cost, quality and availability of health care in the years ahead. The meetings – part of the Society's educational campaign Health Reform: Taking Charge of Change – provide a forum for health care professionals, consumers and business leaders to share their opinions on reform. Co-sponsored by ISMS and the Chicago Medical Society, the first town meeting took place Jan. 26 at Mather High School in Chicago. The program was moderated by Chicago Ald. Patrick O'Connor.

"Doctors have been involved in health system reform since before Clinton was governor of Arkansas," said panelist Alan M. Roman, MD, ISMS president-elect. "Let there be no doubt that physicians are in favor of reform. The question is which kind of reform is best. Physicians have a lot to say, but we also know that we need to listen."

Physicians support some of the goals of President Clinton's Health Security Act, said panelist Sandra F. Olson, MD, CMS president. Those include universal access; a comprehensive benefits package that includes prenatal care, preventive care and immunizations; and insurance reforms such as portability and community rating. But physicians also have some concerns about the plan as currently proposed, she noted.

"We have the best health care in the world. That's no new fact for any of you here," said Dr. Olson. "Our concern is, Will this quality be preserved? We don't want to lose what we have. After all, 71 percent of the people in this country are satisfied with their health care," she noted, citing a September 1993 CBS-New York Times poll.

Most Illinois physicians advocate implementing individual reforms – such as insurance, antitrust and tort reform – that build on the strengths of the current sys-

tem, added Dr. Roman. Enacting tort reforms, namely caps on noneconomic damage awards in medical malpractice cases, is the key to containing sharply rising health care costs, he said.

AUDIENCE MEMBERS OFFERED their ideas for saving money. An advanced practice nurse from Chicago suggested expanding the role of midlevel practitioners, such as certified nurse practitioners. ISMS encourages the



M. Candee Studios

We cannot coerce or simply herd people like sheep into economically driven, factory-like health plans without suffering the consequences.

HEALTH CARE DEBATE

use of midlevel practitioners when they work under physician supervision in delivering health care, Dr. Roman said.

"Certainly, there is a role for midlevel practitioners," Dr. Roman continued. "The approach to cost containment requires a cooperative relationship between the doctor, the patient and other ancillary

simplification," said panelist Victor Bumagin, a training consultant representing the American Association of Retired Persons. "Is it going to be free? No. Is anything free? Of course it's going to cost, but the question is, Will [we get] our money's worth for what we are going to be paying?"

A medical social worker at the University of Illinois at Chicago said that when people without insurance are denied treatment based on their ability to pay, rationing already exists in the U.S. health care system. Reform plans that propose a 20-percent copayment by patients would not reform the system at all because many people could not afford their portion, she said. Patients who could not afford the copayment would be denied treatment, she noted.

Regardless of which entity pays for health care — whether it's employers, insurance companies or the government — we cannot afford to pay for everything for everybody, said panel member Ray Werntz, a member of the Illinois Health Care Cost Containment Council and the Health and Medicine Policy Research Group board of directors. The right balance between what patients pay and what somebody else pays is unknown, he added. But when patients' responsibility for their own health care is de-emphasized, all the proposed plans falter, he said.

"[Patients] really have no role [in any of the reform plans]," Werntz continued. "In my view, shared responsibility is the key to an economically disciplined, viable health care system. Responsibility means there is no free lunch. We must accept the fact that paying the cost of medical care, for some of us, is no more unfair than paying for cigarettes, alcohol, VCRs and nice cars."

Several audience members espoused a Canadian-style health care system for the United States, asserting that all Canadian residents receive free health care. But according to several panelists, the idea that Canadian health care comes at no cost is a myth.

Many people who favor the Canadian system may not have heard that Canada's medical costs are skyrocketing or that according to recent reports, Canadian patients wait an average of five weeks to see a specialist and 14 weeks for some surgical procedures, said Dr. Roman.

"You also probably haven't heard about global budgets," he added. "Global budgets mean that when the money runs out, the hospital closes. Ontario hospitals had to shut operating rooms for the last two weeks of [1993] because they ran out of money. [U.S. citizens] wouldn't stand for that, and well they shouldn't."

The social fabric of the United States is also very different from that of Canada, Dr. Roman continued. The United States has problems with teen pregnancy, drug abuse, crime and violence that are unequaled in Canada.

"If we fail to make the decisions that we need to make with respect to the societal problems that we have, we will end up substituting quality of care for the economic bottom line. And that is something that all of us can ill afford," Dr. Roman said. "So when we talk about reform, let's think about a plan that puts patients first."

ISMS also sponsored town meetings Feb. 3 in Springfield, co-sponsored by the Sangamon County Medical Society; Feb. 10 in Rockford, co-sponsored by the Winnebago County Medical Society; and Feb. 16 in Carterville, co-sponsored by the Williamson County Medical Society. For more information about ISMS' Health Reform: Taking Charge of Change program, physicians may call (312) 782-1654 or (800) 782-ISMS. ■



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Let there be no doubt that physicians are in favor of reform. The question is which kind of reform is best. Physicians have a lot to say, but we also know that we need to listen.

personnel. As long as we can encourage nurse practitioners to work with us as part of this collaborative effort, I think their role will always be there."

Despite the overriding pressure to stabilize expenditures, the sanctity of the physician-patient relationship must not be sacrificed, several panelists said. Reform must respect the physician-patient relationship as a "sacred trust"; therefore, patients should be given as much choice as possible in selecting a health care provider, said panel member Edward A. Cucci, president and CEO of Swedish Covenant Hospital in Chicago.

"I'm concerned that the president's plan does not allow sufficient consumer choice," Cucci added. "The act of healing individuals is a very personal and a very sacred act. Human beings are not commodities and should not be treated as such. We cannot coerce or simply herd people like sheep into economically driven, factory-like health plans without suffering the consequences."

AS CURRENTLY PROPOSED, President Clinton's plan creates 59 new agencies and bureaus and expands the role of 20 existing agencies. That represents more government intervention between physicians and patients, said Dr. Olson.

The increased bureaucracy necessary to implement the Clinton plan also threatens to destroy the physician-patient relationship, which is the basis of the current system, said panelist George V. Duczak, president of Health Reform Coalition Inc. and National Hospital & Health Care Services Inc. "What you will get is a health care system with the compassion of the Internal Revenue Service and the efficiency of the post office at Pentagon prices."

"We must reduce the systemwide rate of increase in health costs by providing administrative savings and

Economic credentialing

(Continued from page 1)

was trying to point out is that how you approach economic credentialing depends on your perspective," said Ray Passeri, the board's executive secretary. In the report, the board developed a working definition of economic credentialing and identified the different positions on the subject, Passeri said. The report uses the definition developed by the AMA, which states that economic credentialing is the "use of economic criteria unrelated to the quality of care" in making hospital staff appointments and reappointments and determining clinical privileges.

Most hospitals that submitted bylaws and application forms to the board indicated that they did not use economic criteria in their physician credentialing decisions, the report said. However, the board concluded that economics was a factor in credentialing throughout the state. "In almost every hospital sampled, some standard or required application element directed itself to an economic rather than a quality evaluation in the credentialing process," the report said. "The difference between actual standards and perceived activity [that is] related to those standards points to the problem in the discussion of economic credentialing as a health care issue."

In addition to obtaining information from hospitals and other organizations, the board held hearings last fall in Springfield and Chicago to compile more details on credentialing practices.

According to the board, hearing testimony indicated concern about various aspects of economic credentialing and revealed that in Illinois, economic criteria are used in the credentialing process, under a broad definition.

"The forms economic credentialing takes are important in that some forms represent a more serious threat to the delivery system, while others can be considered beneficial to the facility, physician and patient," the board summarized. Whether economic credentialing is seen as threatening or beneficial is based on the perspective of those involved, Passeri said.

The board concluded that "forms of economic credentialing can have severe quality implications if steps are not taken to ensure a wide range of input into peer review and program evaluation." The board further noted that its study of economic credentialing is not complete and that a "need exists to clarify those forms of credentialing that represent true economic credentialing from those forms where facilities have the right to apply such economic standards to the betterment of all concerned."

"The board is committed to moving on and pursuing more data," Passeri said, adding that the next step will be to focus on access to care. Testimony indicated that denial of hospital privileges is occurring in Illinois, Passeri noted. However, the difficulty for the board will lie in verifying occurrences of denial and quantifying economic credentialing's effects on access. "It's very difficult to get any data on that." ■

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OBITUARIES

*Indicates member of ISMS Fifty Year Club

*Barber

Kent W. Barber, MD, a general surgeon from Quincy, died Nov. 17, 1993, at the age of 89. Dr. Barber was a 1928 graduate of the University of Pennsylvania School of Medicine, Philadelphia.

*Dorsey

John M. Dorsey, MD, a general surgeon from North Palm Beach, Fla. (formerly of Evanston), died Nov. 12, 1993, at the age of 87. Dr. Dorsey was a 1931 graduate of Rush Medical College, Chicago.

Dvore

Irwin Dvore, MD, an internist from Glencoe, died Nov. 22, 1993, at the age of 74. Dr. Dvore was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

Espinal

Ronald R. Espinal, MD, a family physician from Chicago, died Nov. 7, 1993, at the age of 52. Dr. Espinal was a 1971 graduate of the Facultad de Medicina de la Universidad Autonoma de Guadalajara, Jalisco, Mexico.

Giardina

Jacob J. Giardina, MD, a general practitioner from Vernon Hills, died Dec. 6, 1993, at the age of 83. Dr. Giardina was a 1939 graduate of the Loyola University Stritch School of Medicine, Maywood.

Grodzin

Harvey H. Grodzin, MD, a pediatrician from Wilmette, died Nov. 15, 1993, at the age of 62. Dr. Grodzin was a 1961 graduate of the Wayne State University School of Medicine, Detroit.

Khalili

Ali A. Khalili, MD, a physical medicine and rehabilitation specialist from Oak Brook, died Nov. 22, 1993, at the age of 61. Dr. Khalili was a 1957 graduate of the Faculty of Medicine, University of Teheran, Teheran, Iran.

Learsy

Charles A. Learsy, MD, an ophthalmologist from Chicago, died Dec. 23, 1993, at the age of 98. Dr. Learsy was a 1920 graduate of the L'Universite de Strasbourg, Strasbourg, Bas Rhin, France.

*Linden

Paul R. Linden, MD, a general practitioner from Rock Island, died Nov. 18, 1993, at the age of 90. Dr. Linden was a 1930 graduate of the University of Iowa College of Medicine, Iowa City.

O'Connor

Edward F. O'Connor, MD, an ophthalmologist from Versailles, Mo. (formerly of River Forest), died Nov. 22, 1993, at the age of 74. Dr. O'Connor was a 1945 graduate of Loyola University Stritch School of Medicine, Maywood.

*Okner

Henry B. Okner, MD, a pediatrician

from Oak Park, died Dec. 27, 1993, at the age of 83. Dr. Okner was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

Prager

Paul R. Prager, MD, a general practitioner from Olympia Fields, died Nov. 26, 1993, at the age of 76. Dr. Prager was a 1947 graduate of the Chicago Medical School, Chicago.

*Priest

Fred O. Priest, MD, a gynecologist from LaGrange Park, died Nov. 14, 1993, at the age of 93. Dr. Priest was a 1929 graduate of Rush Medical College, Chicago.

*Rose

Albert H. Rose, MD, a pulmonologist from North Miami Beach, Fla. (formerly of Harvey), died Dec. 10, 1993, at the age of 82. Dr. Rose was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

*Rosenthal

Morris M. Rosenthal, MD, a psychiatrist from Wilmette, died Nov. 29, 1993, at the age of 79. Dr. Rosenthal was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

Scalzo

Silvio M. Scalzo, MD, a family physician from Peoria, died Nov. 17, 1993, at the age of 79. Dr. Scalzo was a 1939 graduate of the University of Louisville School of Medicine, Louisville, Ky.

Steinkamp

John H. Steinkamp, MD, a family physician from Belvidere, died Dec. 16, 1993, at the age of 66. Dr. Steinkamp was a 1954 graduate of the University of Illinois College of Medicine, Chicago.

Suckow

Earl E. Suckow, MD, a pathologist from Mt. Prospect, died Nov. 19, 1993, at the age of 69. Dr. Suckow was a 1949 graduate of Northwestern University Medical School, Chicago.

*Topcik

Aaron A. Topcik, MD, an Ob/Gyn from Jacksonville, Fla. (formerly of Waukegan), died Jan. 6, 1994, at the age of 88. Dr. Topcik was a 1929 graduate of the University of Michigan Medical School, Ann Arbor.

*Wald

Maurice H. Wald, MD, a general practitioner from Chicago, died Dec. 28, 1993, at the age of 83. Dr. Wald was a 1935 graduate of Northwestern University Medical School, Chicago.

Wurtz

Flora B. Wurtz, MD, a radiologist from Arlington Heights, died Nov. 28, 1993, at the age of 71. Dr. Wurtz was a 1944 graduate of the University of Iowa College of Medicine, Iowa City. ■

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Statehouse races

(Continued from page 5)

homes and physicians face an underfunded system that is chronically late in reimbursing providers with reduced payments. Possibly this system should be brought into the private insurance network to achieve greater efficiency.

James A. Dunham (R)

System I recommend: Limited government with full participation by the private sector

Funding sources I support: Combination of some government funding and employer- and employee-paid benefits, sin taxes, and fair contributions by presidents, former presidents and current and former members of Congress

Clinton plan: Oppose

Other plans supported: I am opposed to further government intervention in the health care system, and the alternative plans will be just as wrong as the Clinton socialistic plan in the long run.

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: I support spending caps and some antitrust reform. Public funds should not be used for abortion; insurance should be provided only for catastrophic illnesses and the public should pay for minor health care like dental work. Why would anyone want to destroy the health care system in America, which is the envy of the world, and then entrust his or her body to the care of two political lawyers who currently occupy the White House with only 42 percent of the vote?

111th district

Theodore "Ted" Prehn (R)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: None stated

\$250,000 cap on noneconomic damages: I fully support malpractice reform. This is essential if we are to start controlling health care costs. Limits may be needed; however, I need to research further before committing to an actual cap.

Other reform suggestions: I support antitrust reforms, insurance reforms, requirements that insurers cover preventive health programs, arbitrary spending caps for private and public health programs, and use of pension plans, IRAs and 401(k)s for tax-free insurance purchases. Through training, your association can better educate the medical profession to emphasize service. Too often, consumers feel they are not getting their money's worth. Doctors should make house calls and follow-up phone calls after the first visit, anything to show sincerity.

David Ayres (D)

System I recommend: Government-controlled single payer and public-private partnerships

Funding sources I support: Combination of government funding and employer-paid benefits, sin taxes

Clinton plan: Support

\$250,000 cap on noneconomic damages: Favor

Other reform suggestions: We need to revamp Medicaid. In addition, we must

enact the following reforms at least to some degree: insurance reforms such as community rating and elimination of pre-existing condition clauses, requirements that insurers cover preventive health programs, arbitrary spending caps for private and public health programs, antitrust reforms, and use of pension plans, IRAs and 401(k)s for health insurance purchases.

Steve Davis (D)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits, sin taxes and taxes on health care services

Clinton plan: Oppose in present state

Other plans supported: None stated

\$250,000 cap on noneconomic damages: Oppose

Other reform suggestions: I support insurance reforms such as community rating and elimination of pre-existing condition clauses, requirements for insurers to cover preventive health programs and antitrust reforms. As a state legislator, I would need to assess a plan presented by the federal government to determine the needs of our state and our response.

Gary Dunn (D)

System I recommend: Give President Clinton's plan a chance.

Funding sources I support: Income taxes, employer mandates, combination of government funding and employer-paid benefits, taxes on health care services, sin taxes and gaming taxes

Clinton plan: Support

\$250,000 cap on noneconomic damages: The cap should be lower, such as \$100,000.

Other reform suggestions: Every facet of the system should be reformed to reduce costs. The president's plan has reforms to reduce costs for most taxpayers. I also support insurance reforms such as community rating and elimination of pre-existing condition clauses, requirements that insurers cover preventive health programs, arbitrary spending caps for public and private health programs and antitrust reforms.

Floyd Fessler Jr. (D)

System I recommend: Public-private partnership

Funding sources I support: Combination of government funding and employer-paid benefits

Clinton plan: Oppose

Other plans supported: There are several concepts I support in a number of proposals being addressed.

\$250,000 cap on noneconomic damages: I favor it for specific types of procedures. Gross negligence is and should be the exception.

Other reform suggestions: Although the topic is too complex to reduce to a single fixed answer, I support insurance reforms that establish community rating and eliminate pre-existing condition clauses, requirements that insurers cover preventive health programs and antitrust reforms. Tort reform should include fines and penalties for filing frivolous lawsuits. ■

Antitrust reform

(Continued from page 1)

the lowest cost.

"Under this type of system, we can expect competition to occur at a variety of levels among payers, providers and various health plans, on the basis of cost and quality," McDavid said. "There is substantial evidence that introducing these competitive forces in health care can help moderate the rate of increase of health care costs."

PHYSICIANS COULD LOSE their professional autonomy under the mainstream reform plans as currently proposed, said Sallyanne Payton, a University of Michigan Law School professor. "We all depend on the professional autonomy of physicians to maintain quality of care. There are tremendous difficulties in the physician community today, and I will not deny that there is an incentive to overtreat in the current situation. There are abuses and unnecessary care. But in the end, in the system we have, there is a level of individual responsibility that can only be maintained if there continues to be individual professional liability and financial responsibility."

Any move to force midsize employers into health alliances would eliminate the unregulated marketplace, which is the catalyst driving the reform movement, Payton said. Without competition, health alliances would have no incentive to provide top-quality care or to control costs.

"What we want driving the market is the buyer," Payton said. "But the [group] buyers have trouble developing their PPOs, because the horizontal agreements needed to produce a first-class, integrated, multispecialty organization by contract – rather than by employment – are perceived as violating antitrust laws." The problem is that the agreements require consensus on price, referral and, therefore, market division, she added.

Payton recommends antitrust reforms that would allow purchasers and physicians to establish PPOs that maintain professional autonomy and quality control. To ensure adequate patient choice, a PPO should include 35 percent to 40 percent of the physician market, she said. "That level of market strikes me as being completely unproblematic as long as it is the real purchaser [who] is driving the integration and the integration is being stimulated by the need." ■

AMA launches grass-roots antitrust relief campaign

[CHICAGO] In a Jan. 19 urgent call to action, the AMA requested grass-roots physician involvement in organized medicine's campaign to secure relief from antitrust laws. Currently, those laws prohibit physicians from negotiating quality of care issues with insurers. "The American people will not accept any plan for reform that takes medical decisions away from their own physicians," said James S. Todd, MD, AMA executive vice president.

The call to action urged physicians to contact their U.S. senators and representatives to support the Health Care Antitrust Improvements Act of 1993, introduced as S. 1658 by Sen. Orrin Hatch (R-Utah) and as H.R. 3486 by Rep. Bill Archer (R-Texas).

According to AMA officials, antitrust reform must give physicians the following minimum rights:

- To negotiate with insurers and hospitals on issues such as credentialing, medical treatment policies, utilization review and reimbursement;
- To organize physician-controlled pro-competition networks without fear of antitrust violation;
- To join insurers in forming committees that would have the legal rights to influence medical and other plan policies; and
- To work through professional organizations and professional accrediting agencies – and with public and government participation – to establish standards of quality, treatment, competence and data collection regarding physicians and health care delivery systems.

The AMA worked closely with Hatch and Archer to craft the bills, which would exempt certain collective

activities from antitrust laws if the conduct fell within one of seven safe harbors defined in the legislation or within additional safe harbors designated by the attorney general. In addition, physicians could petition the attorney general for approval of specific activities that fall outside those provisions.

The AMA encouraged physicians to become active in informing the public and Congress about how antitrust reforms would help protect patients from the "increasing domination of America's health care system by giant profit-seeking corporations." Critical activities include discussing health system reform with patients, organizing local reform forums, contacting local media and visiting congressional representatives in their districts.

Physicians are also encouraged to ask their legislators to sign on as cosponsors of the Hatch and Archer bills. Grass-roots physician support would strengthen medicine's position to advocate broader relief measures when Congress addresses reform in the Judiciary Committee and other key committees, AMA officials said. In addition, the AMA invited physicians from every state to participate in a March 8 Washington meeting about medicine's congressional goals.

"Like the AMA, ISMS is working hard to secure reasonable antitrust reform," said ISMS President Arthur R. Traugott, MD. "In fact, the Society will be represented at the Washington meeting. Through ISMS' Washington Presence program, we will continue to push for antitrust relief as a critical aspect of health system reform." ■

— Anna Chapman

Survey

(Continued from page 1)

Coldwater received 2,698 completed surveys. The questionnaire covered various aspects of physicians' practices, providing demographic data ranging from the gender of respondents – 83 percent male, 17 percent female – to their general location – 62 percent in metropolitan Chicago, 17 percent in other metropolitan areas and 17 percent in rural areas. The results showed that 57 percent of respondents are specialists, and 41 percent consider themselves primary care physicians. Nearly half trained at medical schools within the state, and 93 percent are registered to vote.

Forty-nine percent of rural primary care physicians said there are too few of them to meet patient demand. However, most urban primary care physicians, 53 percent, indicated that the number of primary care physicians in their area is about right. Thirty-nine percent of urban specialists said there are too many specialists practicing in their areas, but 52 percent of urban specialists said the number is about right.

OTHER AREAS COVERED in the survey included practice arrangements, resources and environment, professional satisfaction, community environment, hours, services, liability suits and third-party payers. "I was surprised by the number of physicians (67 percent) who said limits by third-party payers have had little or only occasional impact on their medical practice, even though 53 percent of the physicians said they have been prevented from providing a procedure at least once in their career," said Mary Lukens, a Coldwater researcher and partner.

The survey also uncovered a significant decrease in physicians' professional satisfaction in recent years. Sixty-three percent said their professional satisfaction had decreased, and 59 percent said their personal satisfaction had decreased because of changes in the medical practice environment. Further, 52 percent said they would consider retiring before age 65. This figure includes majorities of physicians outside metropolitan Chicago and under age 45.

"The satisfaction and early retirement results send very serious signals," Lukens said. They indicate that recent changes in the medical practice environment have already detrimentally affected physicians, she noted, adding that most of the reform measures affecting physicians are yet to come.

On a positive note for medicine, the survey established that two-thirds of the respondents provide charity care, and most physicians indicated that this practice has increased or stayed the same over the past five years. "Washington doesn't realize the amount of charity care physicians are providing for the uninsured," Lukens said.

The survey indicated that 76 percent of the respondents would be willing to talk to their patients about health care reform issues. The result was consistent across all geographic and demographic groups in the state. That finding should help ISMS disseminate specific reform ideas, Lukens said. "When you think of all the people physicians see in the period of a week or a month, you realize this can be a very effective communication tool."

Blood supplies stable after holiday shortage

[CHICAGO] Area blood centers are recuperating after weathering the worst blood shortage in Chicago in seven years.

"We were really fortunate that people answered our plea," said Pat Grote, spokesperson for LifeSource Blood Services in Chicago. "It really made a difference."

The donation rate is now higher than normal for this time of year, said Lee Cumur, director of community relations for United Blood Services' Chicago office. She added, however, that blood centers

are not counting on the supply to stay at the current level, because individuals may stop donating now that press coverage of the holiday shortage has ended.

This year, the blood shortage affected the entire nation, Cumur said. Donations started trailing off around Thanksgiving, because many people were sick or on vacation. The crisis came to a head toward the end of December and the beginning of January. Christmas and New Year's Day fell on Saturdays, and no blood was donated over two critical three-day periods, she explained. In addition, blood supplies the city usually receives from other parts of the country decreased during that time, Cumur noted.

During extreme shortages, hospitals must decide how to curtail their use of blood, Cumur explained. They may postpone elective surgeries or lengthen the time between blood transfusions for some patients. But other patients require blood immediately, she added. "To our knowledge, no surgeries or treatments were canceled or postponed during the shortage," Grote said.

Blood supplies had been low since June, making it difficult for the center to prepare for the typical holiday shortage, Grote said. "We have now come out of the crisis situation. Chicago has a chronic blood shortage, but we're now back at the comfort level."



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Physicians give
back to
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PAGE 5

FTC provides opinion on fee review programs

FRAUD: Medical societies may conduct peer review and disciplinary proceedings involving physician financial concerns. By Anna Chapman

[CHICAGO] An AMA and Chicago Medical Society proposal aimed at identifying physicians who charge excessively and commit fraud will probably not violate federal antitrust laws, according to a Feb. 17 Federal Trade Commission opinion. The AMA and CMS had asked the agency to determine the legality of requiring physicians to participate in fee review programs as a condition of society membership, the FTC said.

"The American Medical Association and the Chicago Medical Society are pleased with several aspects of the Federal Trade Commission's response to our 1992 petition for an advisory opinion permitting medical societies to discipline fee gougers within the profession," said Kirk B. Johnson, AMA general counsel.

"The FTC has given approval for additional disciplinary activities in two important respects," Johnson continued. "It is now possible for medical societies to require participation in a fee

review program as a condition of membership, and, more importantly, it is permissible for medical societies to discipline members found to engage in fee gouging when fraud and other abuses are present. These are essential aspects of any effective program."

The AMA and CMS proposal encourages county medical societies to operate fee review programs in accordance with general AMA guidelines, CMS officials said. CMS, the largest county medical society in the country, submitted the proposal because it believes that fee review programs are an essential medical society function, officials said. Such review activity should occur at the local level, since that is where peer review is traditionally conducted, according to the society.

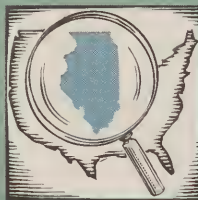
CMS sought the AMA's aid in obtaining the FTC opinion when the society was unable to discipline a physician whose fees were "considered significant."

(Continued on page 15)

INSIDE

New partnership
provides OB
services in
southern Illinois

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ISMS PERSPECTIVE

SUPERVISION IS KEY TO DIRECT REIMBURSEMENT ISSUE

In a December opinion addressing direct Medicaid reimbursement for nurse specialists, Illinois Attorney General Roland Burris failed to comment on the importance of physician supervision – a key component of ISMS policy on physician-nurse relationships.

"It is my opinion that Illinois law recognizes pediatric nurse practitioners and family nurse practitioners, and authorizes them to render services within their specialties and the parameters of the Illinois Nursing Act," Burris wrote. "Therefore the state is required to offer direct Medicaid reimbursement to registered nurses who are properly certified."

But the question of whether nurse practitioners should receive direct reimbursement

from Medicaid does not depend on their certification, said ISMS President Arthur R. Traugott, MD. "The attorney general's opinion confirms what physicians have always believed: Nurse specialists are licensed under the Illinois Nursing Act, and their practice is governed by its parameters. The important question is whether nurses of any specialty are permitted to practice – under the scope of the licenses granted them under the Illinois Nursing Act – without the supervision of a physician. The opinion asks this question but does not answer it directly. The only reasonable inference that can be drawn, however, is that they may not."

(Continued on page 12)



Terry Vitacco

AUCTIONEER SOLOMON ADAMS takes bids during a Feb. 18 art auction sponsored by the Friends of the DuPage Community Clinic. The free clinic will receive a portion of the proceeds from artwork sold at the event.

ISMS, the Blues reach accord on practice guidelines

PARAMETERS: Communication is the key to maintaining quality of care. By Anna Chapman

[CHICAGO] ISMS and Blue Cross and Blue Shield of Illinois came to an agreement in late January regarding the implementation of clinical practice guidelines. In a memorandum to ISMS members, Jere E. Freidheim, MD, chairman of the Board of Trustees, said the two organizations had reached a "broad understanding of each of our respective roles in delivering high-quality, affordable health care to Illinois patients."

The consensus was reached when representatives of ISMS and the Blues met to clarify their support for guidelines as a means of improving the quality of patient care, Dr. Freidheim said. At the meeting, Blues officials explained the insurer's "good faith effort to synthesize practice guidelines published by various national specialty societies," he said.

"It was a marvelous meeting, and a great deal was accomplished," said Arnold Widen, MD, Blues vice president and corporate medical director.

Both the Blues and ISMS recognize that practice guidelines are a part of current medical practice, he said. "As the most important representative of Illinois physicians, ISMS should be very much involved in the guideline selection and improvement process."

"ISMS stands ready to work with any and all insurers, as well as other financial managers of health care resources, formally or informally, to improve the quality of medical care and benefits administration for Illinois patients, payers and physicians," Dr. Freidheim said.

ISMS expressed serious concern last fall when the Blues announced that it was including mandated practice guidelines for cardiology, oncology, general surgery and orthopedic surgery in the contracts of 1,300 specialists. The Blues decided to hold back the orthopedic surgery procedure guidelines for further development.

(Continued on page 12)

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Chicago secures federal funds to fight lead hazards

ABATEMENT: City initiative boasts a loan program to help building owners remove lead. By Anna Chapman

[CHICAGO] Chicago received a needed boost in funds to combat lead poisoning hazards when the U.S. Department of Housing and Urban Development awarded the city a \$6-million grant in December. The grant makes Chicago one of eight cities nationwide to garner funds earmarked to fight lead-based paint hazards in privately owned, low-income housing, said Mayor Richard M. Daley. Other HUD lead grant award winners include New York City, Los Angeles County, Philadelphia and San Francisco.

The new funds will be used to help launch the Chicago Lead Safe Homes Initiative, according to the Chicago Department of Health. Under the initiative, the city will channel some of the HUD funds toward intensive lead poisoning eradication efforts in five city regions. The areas were selected because of their high incidence of poverty, the quality of their housing and the number of lead poisoning cases. The initiative is co-directed by CDOH and the Chicago Department of Housing.

The bulk of the grant will be directed toward establishing a low-interest or forgivable loan program to help building

owners remove lead hazards, said John Knox, executive director of the Lead Elimination Action Drive. In addition, the grant will finance the temporary relocation of families to lead-safe housing during abatement of their homes. Inspectors from the Department of Buildings will be equipped with lead-testing kits to obtain initial lead level readings, allowing the department to target homes that need more comprehensive lead testing.

Over the next two years, the city will match the federal funds with nearly \$8 million of in-kind services from CDOH and the housing department, CDOH announced.

"We are encouraged by this important federal award and stand ready to launch this initiative to protect the children in these communities at greatest risk," said Housing Commissioner Marina Carrott.

Because of the critical issue of lead poisoning in children, ISMS House of Delegates policy supports legislation establishing lead abatement programs.

According to the Illinois Department of Public Health, more than 20,000 Illinois children tested positive for lead poisoning in 1993. ■

More doctors finding benefits to group practice

[CHICAGO] Physicians in group practices feel fewer restrictions on their autonomy, see more patients, are more likely to be board-certified and contract with HMOs, and have somewhat higher incomes than doctors in solo and other practice settings, according to results from a new AMA study. The survey, "Physicians in medical groups: A comparative analysis - 1993," also revealed that 33.4 percent of U.S. physicians who care for patients directly are now involved in some type of group practice. That's up from just 18 percent in 1969, the AMA said.

The study is the first of its kind to focus on individual physicians practicing in groups and not on the group itself, according to AMA Executive Vice President James S. Todd, MD. It was conducted to provide doctors with new data about the practice of medicine, Dr. Todd said. "Most of the health system reform proposals on the table today involve health providers' 'organizing' in some way to provide more cost-effective, comprehensive and high-quality health care. Anyone attempting to anticipate and comprehend health system reform will therefore need more information on physicians and how they're practicing. That's the kind of information now available in [the study]."

According to the survey, 34 percent of physicians are still practicing in solo or two-doctor practices, and 32.6 percent are practicing in other settings, such as hospitals, or have temporary employment arrangements. The survey also uncovered, however, that on average, patients wait longer for appointments and in waiting rooms if they are seeing

doctors in group practices.

To order a copy of the survey results, physicians may call (800) 621-8335 and request publication OP#392993CH. The cost is \$75 for AMA members and \$95 for nonmembers. ■



Terry Vitacco

WAYNE N. LEIMBACH, MD, an Aurora internist, discusses health care reform during a radio talk show on station WBIG in Aurora. Nearly 100 Illinois physicians have participated in ISMS' speaker training during the past year in preparation for similar public outreach efforts.

JCAHO establishes network accreditation standards

[OAKBROOK TERRACE] A new program launched in January by the Joint Commission on Accreditation of Healthcare Organizations makes health care networks eligible for JCAHO accreditation. Industry experts estimate that 1,000 to 1,500 health care networks will be created as a result of reform, according to JCAHO.

The program establishes standards that will enable JCAHO to evaluate and accredit health plans emerging in the changing medical marketplace, said JCAHO President Dennis S. O'Leary, MD. It was developed with input from more than 100 health care executives, managed care experts, policy-makers

and business leaders nationwide, he added.

"The Joint Commission has always provided accreditation services to organizations in the mainstream of the health care delivery system," Dr. O'Leary said, citing as examples hospitals and other organizations that provide long-term, mental health and ambulatory care and home care services. "This new program provides a framework for networks that will be part of that mainstream health care system to continuously improve their level of performance and demonstrate their achievements to purchasers and the public."

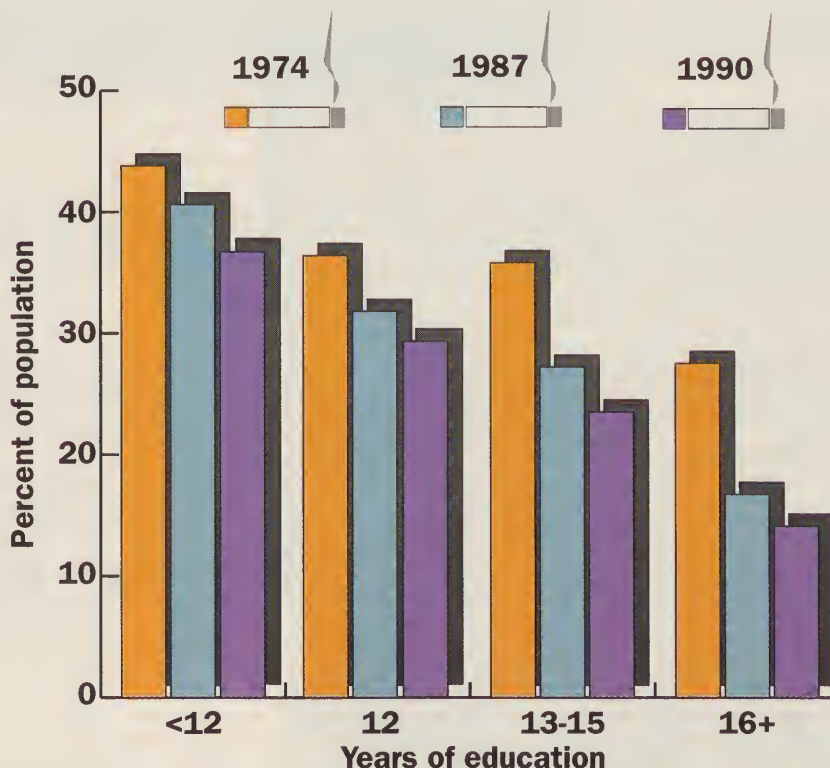
Networks will be evaluated on their performance in the areas of patient rights and responsibilities, organization ethics, continuum of care, education and communication, leadership, human resources management, information management and improvement in network performance. Most of the new health care partnerships are expected to include organizations that have already obtained JCAHO accreditation. However, if a network includes nonaccredited entities, such as a hospital, nursing home or home care organization, evaluations of the clinical care delivered within the network will be based on standards currently in place for those types of health care delivery sites.

Organizations that lack accreditation may also show compliance with JCAHO-acceptable standards or participate in surveys conducted at a network's request. Third parties such as state agencies and purchasing alliances will also be able to request surveys under the program, according to JCAHO. Surveys are scheduled to begin this spring. ■

PHYSICIAN FACTS

Smokers and their education

Cigarette-smoking trends for Americans age 25 and older, by education



Source: Health Interview Data, National Center for Health Statistics, as reported in *Heart and Stroke Facts: 1994 Statistical Supplement*, published by the American Heart Association

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Discovery question stems from hospital lawsuit

INVESTIGATIONS: A state Supreme Court decision may have implications for physicians. By Anna Chapman

[SPRINGFIELD] A 1993 Illinois Supreme Court ruling allows information obtained by a hospital department head – independent of peer review – to be used as evidence in a malpractice suit. As a result of that ruling, a case involving an injured newborn has been remanded for a new trial.

In *Roach vs. Memorial Medical Center*, the Supreme Court reconsidered and reversed its own ruling that disallowed use of information gathered by Gary A. Draper, MD, chairman of the anesthesia department at Memorial Medical Center in Springfield. At issue in the court's decision was Dr. Draper's hallway discussion with labor and delivery nursing staff about a delay in securing anesthesia services required for an emergency cesarean section.

The infant, Kayla Roach, allegedly suffered injuries when a 13-minute delay occurred after the obstetrician requested anesthesia services. In his investigation, Dr. Draper sought to determine why anesthesia was delayed, since the anesthesiologist was in the hospital at the time, said Saul Morse, ISMS general counsel. According to an Illinois Hospital Association memorandum about the case sent to its members in October 1993, the delay was caused by an inexperienced clerk who did not know the best way of paging anesthesia personnel. The memo also states that Dr. Draper reported his findings to the anesthesia department as part of peer review and quality assurance procedures.

The plaintiffs originally sued the hospital and two physicians involved in the incident, said Paul Bown, attorney for Memorial. The trial concluded in 1991 with a decision in favor of the hospital and the physicians.

In a December 1992 ruling, the Supreme Court said Dr. Draper's evidence was privileged under the Illinois Medical Studies Act, which provides that information used by hospital committees in the course of conducting peer review or internal quality assurance activities is not subject to discovery. However, in reconsidering the issue, the court overturned its decision in September 1993, finding that Dr. Draper had not been preauthorized by a hospital peer review committee to conduct an investigation. According to the court's September 1993 opinion, the Act protects only information obtained by a committee and applies only to medical staff committees involved in the peer review process.

In reversing the verdict for the hospital, the Supreme Court determined that discovery of Dr. Draper's evidence should be allowed, said Ted Nodzenski, IHA associate general counsel.

In its memo, IHA recommends that hospitals revise their quality assurance policies to "ensure that information and data are generated by or at the request of formally created hospital committees." Changing those policies may require amendment of medical staff bylaws so that they "unambiguously designate departments as 'committees' for purposes of the Medical Studies

Act," the IHA memo states. In addition, IHA suggests that such amendments allow authority to be conferred on an individual committee member, such as a department chairman, to "conduct quality assurance investigations as necessary, on behalf of the full committee."

The IHA memo aimed to help hospitals establish a mechanism for protecting from discovery any information that is gathered by department heads and that may be used in malpractice lawsuits, said Nodzenski. That protection would be provided under the Medical Studies Act, he added. IHA wants hospitals to develop protocols to enable department heads to investigate adverse incidents and report back to the committee, which could be the department, within a specific time frame, Nodzenski said.

"It's fair to say that we would be troubled by giving too much authority to a single individual" during the course of peer review and quality assurance pro-

ceedings, said ISMS' Morse. Although it is essential to keep confidential the information gathered in the peer review process, it is equally important that investigative activities remain a medical staff committee function, he added.

"The question is whether it is appropriate and necessary to designate a person to investigate incidents before they occur," Morse noted, citing as an alternative a situation in which committees meet after an incident to authorize an investigation. In addition, medical staffs that are considering changing their bylaws should confer with independent counsel, according to ISMS advisers. ■

Blue Cross Blue Shield



REPORT

FOR *Illinois Physicians*

MEDICARE PART A

APPROPRIATE COMPLETION OF LABORATORY AND X-RAY REQUISITIONS

When UB-82s or UB-92s are keyed or submitted to Medicare Part A, they are often denied at the initial submission level due to incomplete or incorrect coding. Subsequently, beneficiaries submit additional documentation at the reconsideration level, indicating that the facility initially coded the claim for a screening rather than as a diagnostic procedure. The additional information allows reversal of the original decision and payment of the claim. These coding problems are time consuming and costly to process, and cause a delay of payment to providers.

Appropriate use of ICD-9-CM, HCPCS, and revenue codes could prevent this needless repetition of service and result in prompt payment of claims. The most frequent coding problems encountered are with the billing of routine medical examinations, Pap smears, and screening mammograms.

Routine medical examinations, including those performed without treatment or diagnosis of a specific disease, symptom, complaint, or inquiry are not covered services (Hospital Manual Section 260.7).

Incoming claims with revenue codes for laboratory or diagnostic tests must have appropriate ICD-9-CM codes which reflect the fact that the patient has an actual medical diagnosis, symptom or chief complaint. Facilities should not code these claims using ICD-9-CM codes V700-V829. These non-specific codes are only appropriate for routine medical examinations and screenings, and reimbursement will not be made to the billing facility for them. **If a "V" Code is used as the principal diagnosis, providers should make every effort to identify a secondary diagnosis prior to initial submission of the claim.**

In order to assist facilities with the correct coding, it is **imperative** that you correctly identify if a test is being performed for **diagnostic** purposes or **screening** purposes.

New partnership provides OB services in southern Illinois

ACCESS: Pregnant women in rural areas may now see physicians for prenatal care. By Kathleen Furore

[HARRISBURG] Until last month, pregnant women in Harrisburg and its surrounding counties had two choices: travel 40 miles or more to see an Ob/Gyn in Carbondale, Evansville or Paducah, Ky., or forgo prenatal care.

But now, pregnant patients are receiving prenatal and obstetrical care at the Harrisburg Family Practice Center, since Ob/Gyns from the Carbondale Clinic are serving as backup consultants for Harrisburg family physicians. The partner-

ship between the Carbondale Clinic and the Harrisburg Family Practice Center is one in a series of programs being coordinated by the School of Medicine at Southern Illinois University under the state's Rural Health Initiative.

The goal of the ISMS-supported initiative, which was signed into law in 1990 and funded by the General Assembly in 1993, is improving the delivery of health care services in Illinois' rural and designated-shortage areas, according to the enacting legislation.

"We decided to focus on the identified need to develop prenatal and obstetrical care services, especially for the 1993-94 fiscal year," said Ray Robertson, assistant provost at SIU medical school, who conceived and helped develop the initiative. Harrisburg was selected because no prenatal care was available in the city or its surrounding counties, Robertson explained. "Some women had to travel an hour and a half each way [to get care], and many are on public aid and have no car and no resources."

The partnership has enabled women to seek prenatal care closer to home. As part of the program, Carbondale Clinic Ob/Gyns travel to Harrisburg on a rotating basis, making sure they see each patient at least twice prior to delivery, Robertson said. Harrisburg family physicians now provide routine prenatal care in consultation with the Ob/Gyns.

The arrangement also allows patients to meet the Carbondale doctors who will deliver their babies, Robertson noted. Women typically deliver at Carbondale's Memorial Hospital because the Harrisburg clinic lacks the funds to create or operate an obstetrical unit, he said. Emergency procedures and protocols have been developed in case a patient must deliver in Harrisburg, he added.

Although it has been operational only a few weeks, the program is becoming popular with patients and physicians. In the first two weeks of the program, Carbondale Ob/Gyns had examined about a dozen pregnant women in Harrisburg — twice the number that Larry R. Jones, MD, a Harrisburg family physician, said he and his colleagues had expected to see.

"Initially, I had some hesitancy because I think most women develop a close personal relationship with their physicians during pregnancy and want to have the physician who has been seeing them deliver their babies," Dr. Jones

explained. "But the program has been well-received by my family practice patients. They tell me they like the idea of seeing me at least partially throughout their pregnancies. And the others [who weren't patients previously] are just thrilled by the services here and are happy they don't have to travel 60 miles each way."

Robertson added that the program is not an exclusive arrangement between the Harrisburg and Carbondale practices. "Other doctors can participate, not just those from Harrisburg," he said.

THE PARTNERSHIPS formed under the Rural Health Initiative should also yield benefits in patient care and cost containment, according to Robertson. He noted that of the approximately 8,000 babies born in Illinois' 30 southernmost counties in 1990, more than 400 were high-risk infants. That high rate was caused mainly because of a dearth of prenatal care, he said.

"It costs about \$75,000 to care for each high-risk baby. And a high-risk baby can be a high-risk kid for a long time. It doesn't stop in the neonatal intensive care unit," Robertson said. "If we can improve prenatal care and patient compliance and have even 10 fewer high-risk babies, \$750,000 in just front-end costs will be saved."

According to Carl J. Getto, MD, dean and provost of the SIU School of Medicine, estimates show that for each dollar spent on prenatal care, \$4 will be saved in postnatal or high-risk care. "So not only will this relationship be good for the mothers and their babies, but [it] also is a better use of health care dollars, which is consistent with new trends in health care delivery," Dr. Getto said.

In addition to increasing the availability of prenatal and OB services, the partnerships will focus on coordinating normal and emergency patient transportation, facilitating transfer of medical records through an on-line computer system, expanding patient education activities and collaborating with other programs — such as the state's Healthy Moms/Healthy Kids — for ancillary services.

"We can't solve all the problems," Robertson concluded. "But we're as excited as we can be about this program and the other opportunities that exist in this region."

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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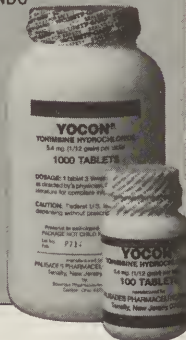
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1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
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The Carbondale Clinic's chief operating officer William R. Hamilton, MD (second from left), and Dr. Jones (second from right), accept plaques designating their facilities as partners in the Rural Health Initiative. Joining them are Dr. Getto (far left) and Roger N. Klam, MD, an Ob/Gyn at the Carbondale Clinic.

Physicians give back to the community

PHILANTHROPY: A donation of land helps bring the arts to Morton. By Kathleen Furore

[MORTON] Sixteen years ago, four physicians had 27 acres of land and a dream: to develop a major medical complex and possibly a nursing home, park or progressive care facility for the residents of Morton.

Today, thanks to the generosity of those physicians, 17 of the 27 acres belong to the Bertha Frank Foundation, a private charitable organization that will use proceeds from the sale of the land to fund a community arts center for the tight-knit community of 15,000.

"We bought the land in 1978 and built the Morton Medical Center on 10 of the acres. There were no large medical complexes in Morton at that time. We recruited 23 or 24 doctors. The community had never had access to that kind of care before," said John J. Taraska, MD, a Peoria pathologist with an office in the medical center. He noted that the center offered X-ray, lab and physical therapy services that residents had previously traveled miles to receive. "But we couldn't get financing for the nursing home we'd been thinking of building. So when we sold the medical center to Methodist Medical Center and St. Francis Hospital [in Peoria], we decided to sell the other 17 acres."

Instead, Jim Maloof, a local real estate developer and mayor of neighboring Peoria, suggested donating the land. "Jim Maloof mentioned that we all had professional involvement in Morton and asked, 'Why not give the land to the foundation for the performing arts center?'" Dr. Taraska said. "I talked to my partners, and they agreed. And the [Bertha Frank Foundation] took possession of the land in late December of 1993."

There was one hitch, though. Bertha Frank, a longtime Morton resident who had bequeathed the village an estate valued at about \$465,000, had specified that the money be used to build a performing arts center on the grounds of the local high school.

"We still gave the land, with the understanding the foundation could sell it and use the income to fund construction of a center next to the high school," explained Dr. Taraska. "Right now, they're collecting money from renting the land to farmers. They'll do that until they need to sell it, since construction of the arts center is at least a year away."

ONCE CONSTRUCTED, the Bertha Frank Performing Arts Center will be the setting for community events and performances by area artists. And no one could be happier than Jim Yordy, chairman of the Performing Arts Center Committee.

"This is one of the most dramatic things that has ever happened to our community," Yordy said. "We don't have a place, other than churches, to hold concerts, so this is critically important to our quality of life. It was so exciting when the doctors gave us the land; it was a major contribution. And now we're almost one-third of the way to our goal, and we haven't had an official fund-raiser yet." Yordy said he hopes construction for the proposed 500-seat center will begin by spring of 1995.

The physicians whose donation

brought the arts center a step closer to reality are happy, too. Dr. Taraska and another donor, Thomas W. Clark, MD, an internist at the Morton Medical Center, said they are pleased to be able to show their appreciation to a community that has been supportive of them for many years.

Michael D. Cashman, MD, a gastroenterologist and chief of medicine at Methodist Medical Center, called find-

ing such a worthwhile use for the land "exciting" and expressed surprise at the "outpouring of goodwill" he and his colleagues have received in response to their donation.

Another physician donor, Carl W. Soderstrom, MD, chief of dermatology at St. Francis Hospital and a member of the center's medical staff, summarized what the donation of the land and construction of the arts center mean to the

doctors and the citizens of Morton: "I've lived in Morton for 20 years and reared five sons here. I love my patients and my profession and have always wanted to give something back. The school and community need arts, stages, music. We have great teachers, but we need better facilities. What this center will do is bring those things to Morton, and it feels nice to be able to do something like this for the community." ■

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EDITORIAL

In recognition of doctors

This month, we celebrate Doctors' Day. March 30 has been set aside to honor physicians who dedicate their careers to caring for patients and advancing medical technology.

It all started 152 years ago. On March 30, 1842, Crawford W. Long, MD, administered ether anesthesia before removing a tumor from a patient's neck. The patient later said he felt no pain and did not realize the operation had been completed until he awoke. That milestone in medical history was the impetus for the celebration of Doctors' Day by medical institutions and communities nationwide.

To honor Dr. Long and to recognize the dedication and achievements of physicians like him, the Barrow County Auxiliary observed the first Doctors' Day on March 30, 1933. Congress first declared an official observance of a national Doctors' Day in 1958. And in 1991, Gov. Jim Edgar signed a Doctors' Day proclamation encouraging "all citizens to be more attentive to their medical needs so we may remain a healthy, prosperous state."

It's true that Doctors' Day recognizes the achievements of physicians like Dr. Crawford. George Bush's 1991 presidential proclamation of national Doctors' Day also cited Drs. Daniel Hale Williams and Charles Drew, "who not only advanced their respective fields but also brought great honor and pride to their fellow black Americans." In addition, the president paid tribute to Drs.

Albert Sabin and Jonas Salk, whose vaccines for poliomyelitis "helped to overcome one of the world's most dreaded childhood diseases." Finally, President Bush recognized the humanitarian efforts of Dr. Thomas Dooley, as well as physicians leading the nation's fight against AIDS, cancer and other life-threatening diseases.

However, those physicians with recognizable names and visible achievements aren't the only ones who will be honored this month. The day commemorates every doctor who treats patients and serves as their advocate. Whether primary care physicians or specialists, researchers or clinicians, doctors have something in common — years of training and daily hard work and personal sacrifice.

Many physicians even go beyond their everyday activities of diagnosing and treating patients. For example, they work with community leaders to develop and staff clinics for the indigent. Such clinics can be found in Sangamon County, Will-Grundy counties and elsewhere across the state.

The fact that doctors are performing good works was confirmed by a recent ISMS survey, which showed that two-thirds of the respondents provide charity care. Most physicians indicated that this practice has increased or stayed the same over the past five years.

On Doctors' Day this year, let's remember the good things we've done for our patients and give ourselves the credit we deserve.

PRESIDENT'S LETTER

Advocating patient care

By Arthur R. Traugott, MD



In advocating for patients, we will continue to find ourselves in new arenas.

At top priority for ISMS is maintaining a health care environment in which physicians can continue to provide high-quality patient care. That concern resulted in ISMS' requesting a meeting with Blue Cross and Blue Shield of Illinois in late January. Specifically, we were worried about the mandatory practice guidelines imposed by the Blues last fall. At the meeting, we discussed our concerns about the development of the guidelines and their potential effect on patient care, as well as the question of whether the insurer solicited broad-based physician input. We made our case strongly and convincingly. We were able to exchange information and agree to cooperate on this issue and others that potentially affect the quality of patient care in our state.

That is just one example of how confrontation can occur between the changing health care environment and the goal of providing quality medical care. In advocating for patients, we will continue to find ourselves in new arenas. You, too, may be facing new problems today. That's the reason ISMS has launched the Medical Leadership Initiative — a statewide program to gather information about members' circumstances and needs.

We've heard from many of our members that they are concerned about economic changes in the practice of medicine. They've said they want help in understanding exactly what those changes are and how they will affect their practices. ISMS is dedicated to helping meet members' needs for information and services.

Toward that end, the ISMS Board of Trustees has taken several specific actions. First, it has placed strong emphasis on ISMS' Washington Presence program so that Illinois physicians are represented in the national health care reform debate. ISMS is also practicing aggressive legislative advocacy to remove or change the objectionable features of the Clinton reform proposal. Organized medicine is fighting for you on many fronts, and we can't afford to

ignore any of them. Most important to ISMS are antitrust relief for physicians and caps on noneconomic damages in malpractice awards.

Second, ISMS is studying the feasibility of forming a physician network, a PPO, a clinic without walls, an IPA or an HMO. Some other state medical societies have already formed such organizations. We hope to determine soon whether one of those options would meet the needs of Illinois physicians.

Third, the board directed ISMS to explore services that would help you, our members, deal with the many changes in the practice environment of today — and tomorrow. Specifically, those changes include a shift toward integrated managed care. The term "managed care" means different things to different physicians. In general, it refers to a method of providing health services within a defined network of providers who are responsible for managing and providing high-quality, cost-effective health care to a defined population.

Managed care is an increasing trend in Illinois and nationwide. More and more, employers and insurers prefer to deal with networks that coordinate care, combining health care services into "one-stop shopping." They are moving away from paying for services individually.

By providing you with new services, ISMS is striving to empower you to negotiate effectively and to provide information and advice to your patients. ISMS wants to support you, on behalf of your patients, in managing the impact of managed care.

As part of the MLI program, I've recently made trips with other ISMS representatives to meet with physicians at county medical society meetings and medical staff meetings. We hope that you will take advantage of the opportunity to talk to the MLI teams about the practice of medicine in your community and the services you need.

In advocating for our patients, we will continue to confront new issues, but we'll do so together.

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GUEST EDITORIAL

Health plan has many layers

By Murray Weidenbaum

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Whether or not you like the Clinton health care reform proposal, an examination of the details reveals that it would impose a large amount of new bureaucracy on medical care in the United States. In fact, five new levels can be identified.

At the top of the health care system pyramid will be a new seven-member National Health Board. It will oversee state plans and the functioning of health alliances. The board also will administer and update the package of benefits guaranteed each person and enforce the national health care budget. A committee of the board will monitor drug prices and identify those it feels are "unreasonable."

Each state will be required to set up its own bureaucracy to carry out a host of new functions that will be imposed on it. These will include establishing and overseeing new health care alliances (one or more per state), qualifying health plans and overseeing their financial viability and establishing "capital" standards for health plans to meet federal standards. Each state will also operate a guarantee fund.

In practice, healthy plans will bail out sick ones, as we will see. If the states do not meet their new "responsibilities," the feds will punish them or take over their responsibilities. In that event, the federal government can levy a 15-percent surcharge on all health insurance premiums to finance its new bureaucracy.

Health care alliances are the third level. Each state will determine the structure of its alliances. They could be state agencies or nonprofit corporations. Consumers and employers are to be equally represented in the management of each alliance, which should make for an interesting management structure. Each alliance will negotiate with health care plans to determine which of them will be authorized to provide the comprehensive benefits package. The alliances will enroll members in health plans – and everyone must join. Each alliance sets fee schedules for doctors and provides information on quality and costs of the different plans.

Alliances can borrow from the Department of Health and Human Services to cover cash shortfalls. Thus, a new credit program is in the making. The Council of Economic Advisers estimates that the regional alliances will need 50,000 new hires – that's at least \$1 billion in addi-

tional overhead.

Health plans are the fourth level. They may be organized by insurance companies, hospitals or other health care providers. Each plan must accept any eligible member – unless it is already oversubscribed. The plan may charge a standard fee for each member (comparable to current health management organizations or HMOs), a fee for service or a combination. Fee for service means choosing your own doctor, as at present. However, the patient will have to pay out of pocket a much larger percentage of the doctor or hospital bill than if he or she enrolls in an HMO-type plan.

Finally, at the fifth and bottom level of the pyramid we come to health care providers. They actually take care of sick people. But only if they are part of a plan approved by a health care alliance.

Even though the talk is all about patient power, the Clinton proposal contains a great many punitive provisions in the event that people do not conform to the details. For example, if a person does not want to enroll in any health care plan, the regional alliance will do it for him or her – and double the regular premium.

If a plan has generous provisions – costing 20 percent or more above the regional average – it will be excluded. Thus, the plan will not be available to anyone, even if people want to pay for it out of their own pockets. So much for the alternative of "fee for service" plans and patient choice. Doctors will be fined for departing from "targets" set by alliances and the National Health Board. Ditto for health insurance plans.

The notion that the Clinton plan avoids price controls by calling the result "targets" is clearly disingenuous. Similarly, it converts what are now voluntary insurance premiums to compulsory taxes, but avoids changing the label. In addition, the Secretary of Labor can assess each corporate alliance up to 2 percent of its insurance premiums to finance a new Corporate Alliance Health Plan Insolvency Fund.

Clearly, the Clinton plan contains price controls and taxes, but under different names. The American people should be aware of the added bureaucracy – and cost – of this health care reform proposal.

Weidenbaum is director of the Center for the Study of American Business at Washington University in St. Louis.

GUEST EDITORIAL

Clinton health plan is bad medicine

By Edward F. Ragsdale, MD

The health care available in the United States is easily the best in the world. We have access to modern technology, innovations from leading drug companies and advanced surgical procedures.

In fact, our health care is so good that leaders and dignitaries who are from other countries and who are seriously ill often come to the United States to obtain treatment. On a recent visit to the Cleveland Clinic, I found that 20 percent of the patients were Canadians who wanted better or more rapid treatment than they could receive within their national health system. If people have to wait 10 months for a coronary bypass, as is the case in Canada, many of those individuals may not be alive when their number for surgery comes up.

Recently, U.S. Sen. Daniel Patrick Moynihan (D-N.Y.), who sits on the powerful Senate Finance Committee, proclaimed that there is a welfare crisis in the United States, not a health care crisis. The debate about whether there is a health care crisis ebbs and flows, as does support for how far health care reform should go. Due to free market forces, the price increase for medical care is moderating, with only a 5-percent rise in 1993. So there seems to be good reason to enact reasonable reforms to improve our health care system, not radically change a system that is the envy of the world.

The Clinton administration's health reform plan was drawn up by liberal lawyers and bureaucrats and was designed to make the middle class dependent on government to help re-elect Clinton in 1996. Fortunately, the more information people receive about the president's plan, the less support it has.

Many of the individual health care reforms in the Michel and Graham proposals should be enacted immediately. Those reforms that would enhance and improve the nation's health care system are the following:

- Insurance market reforms to make health insurance stable and portable;
- Limits on pre-existing condition restrictions in health insurance and employer-supplied health plans;
- Elimination of barriers to small business owners' forming insurance pools;
- Decreases in health insurance premiums achieved by making them tax-deductible;
- Establishment of medical savings accounts;
- Tort reform to reduce related health care costs;
- Administrative reforms to simplify

paperwork;

- Reduction in Medicare and Medicaid expenses attained by lifting regulatory burdens; and
- Health insurance tax credits or vouchers for low-income families.

The potential cost savings from some of these measures would be significant. According to estimates, upward of 25 percent in related health care costs could be saved through tort reforms, and Medicaid and Medicare costs could be lowered by 5 percent if regulatory hassles were curtailed.

These reforms can be accomplished at reasonable cost and will strengthen our system, not destroy it as is likely under the Clinton plan. The president's plan has several major defects. Its proposed funding mechanism is deceptive and grossly underestimated. The proposed "premiums" on businesses could be raised by the health care boards and alliances without a vote in Congress. These premiums will threaten the creation of jobs and slow economic growth.

The Clinton plan also severely restricts individuals' freedom to choose their own doctors, buy additional health insurance and seek additional treatment outside the community. Fines of up to \$15,000 are proposed for violators.

Under the Clinton proposal, bureaucrats would make many health care decisions. They would determine eligibility for certain medical procedures and treatments. For example, kidney dialysis could be limited to people under the age of 50.

In addition, the quality of health care would decline under the Clinton plan. Gatekeepers would limit patients' ability to see specialists. And patients might be required to see a nurse or other midlevel practitioner instead of a physician. Costs would be controlled by waiting lines and shortages.

Health care coverage for all Americans will be affected by the health care debate. For most people, the Clinton plan would provide less coverage at higher cost than their current health plan. Overall, the Clinton plan means higher taxes, lower quality, less choice and more restrictions.

It's critical that we all take a few minutes to write our senators and representatives to express our concerns about the Clinton plan and others like it that would be bad medicine for health care in America.

Dr. Ragsdale is a radiologist in Alton and serves as chairman of the Madison County Republican Central Committee.

If people have to wait 10 months for a coronary bypass, as is the case in Canada, many of those individuals may not be alive when their number for surgery comes up.

Missouri-based risk retention group folds

MALPRACTICE INSURANCE: Physicians lose coverage because of the liquidation of an unregulated insurer. By Kathleen Furore

[KANSAS CITY, MO.] In a move that affects 32 Illinois physicians, U.S. Physicians Mutual Risk Retention Group of Missouri has been liquidated, leaving policyholders without coverage as of Feb. 17. The liquidation underscores the risks physicians take when they select an unregulated risk retention group to be

their malpractice insurance carrier.

U.S. Physicians Mutual operated in 20 states and had 446 policies in force at the time of its liquidation, according to Arnold Dutcher, deputy director of the Illinois Department of Insurance's financial corporate regulatory division. As of Dec. 31, 1993, the risk retention group

had \$741,228 in Illinois premiums in force, he said.

Because the group was not licensed in Illinois, its policyholders have little, if any, recourse to recover the premiums they have paid, said Saul Morse, ISMS general counsel. "Physicians potentially could seek recovery of premiums

through bankruptcy court in the state where the company liquidated, but it is unlikely that anything will be there for them. This was an unregulated risk retention group. If it had been a regulated carrier, there would have been some protection through the guarantee fund."

Regulated insurance carriers must pay into a guarantee fund, which offers protection in case the insurer is forced to liquidate its assets. Risk retention groups are federally exempt from contributing to such funds. They may incorporate and then be licensed in just one state to do business in other states.

For U.S. Physicians Mutual policyholders involved in litigation, the news is even worse, Morse said. "They're pretty much uninsured for the time period during which they'd been insured. They'll have to apply to other insurers for future events. If they're already being sued and if that risk retention group was paying for their legal fees, they'll have to try to work it out with the lawyers involved. Most likely, there isn't a pool of money to cover defense costs or any award made to the plaintiff."

PHYSICIANS OFTEN SELECT risk retention groups because they offer lower premium rates or because doctors have been denied insurance by other carriers, according to Morse. But the lower rates are often responsible for failures like the one experienced by U.S. Physicians Mutual, he noted.

"Sometimes these groups can charge less because they're small and don't have all the costs that come from being regulated, they don't have the same level of financial resources as regulated companies and their rates aren't based on realistic expectations of what payouts will be," Morse explained.

To avoid getting caught in such a precarious situation, ISMS liability insurance advisers recommend that physicians try to determine the financial health of insurance carriers. For example, longevity is an important aspect to consider, the advisers said.

"You have to realize this is a long-tail casualty business. In a worst-case scenario, it can take five to 10 years between the time a suit is filed until it is settled," according to one ISMS adviser. "That's why you need somebody with longevity — a carrier who's been in the game for a while and someone who's going to stay in it for the long haul. The process of disposition and adjudication is long and arduous, and you need a company with the financial resources to withstand that process."

ISMS advisers offered the following advice to doctors attempting to verify a carrier's fiscal strength and overall reputation:

- For regulated companies, obtain and review the annual reports filed with state insurance commissions and those distributed to stockholders and policyholders. "Look at what the numbers say and what the auditors say," one adviser suggested.
- For unregulated risk retention groups, ask for copies of independent audits.
- If an independent actuary determines company rates, request a copy of the actuarial report.
- Find out what your hospital will accept as evidence of coverage. "Hospitals require proof of coverage and normally make judgments about what's acceptable and what's not," the adviser said. ■

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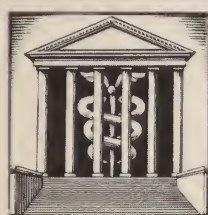
Discovery
question
arises in
hospital suit

PAGE 3

HMO hit with \$89-million verdict

TREATMENT: The largest award ever against an HMO spotlights rationing in the health system reform debate. By Gina Kimmey

[RIVERSIDE, CALIF.] On Dec. 28, a California jury ordered a health maintenance organization to pay \$89.3 mil-



lion to the estate of a breast cancer patient who was denied insurance coverage for a bone marrow transplant. Although the insurer has said it will appeal, the case again raises the question of which procedures should be covered under health system reform. Although some Illinois oncologists still consider bone marrow transplants to be experimental, they say payment for such clinical trials is necessary to advance the quality of medical care.

"I don't view [bone marrow transplants] as experimental; I view them as being in the midst of clinical trials," said Leo I. Gordon, MD, an oncologist at Northwestern Memorial Hospital. "I think [this verdict] is a very important decision because it raises the message that bone marrow transplantation for breast cancer has shown proof of effectiveness in enough patients that it ought to be covered by insurance companies."

Whether or not bone marrow transplants for breast cancer patients are experimental is the \$64,000 question, said an oncologist at Rush-Presbyterian-St. Luke's Medical Center. She said oncologists have a good idea of six-month, one-year and two-year survival rates after treatment. But what is not known is whether the treatment is curative in some patients and whether it surpasses standard chemotherapy as a treatment for recurrent breast cancer.

According to Samuel G. Taylor, MD, another Rush oncologist, the American Society of Clinical Oncologists advocates that health system reform include coverage for patients who participate in research studies. He said any reform plan that includes and encour-

ages the use of clinical trials to define the best treatment program will truly improve the quality of medical care.

"That would be a reform over what the insurance industry to date has advocated," said Dr. Taylor. "In fact, if you were to call any insurance company today and ask them if they will pay for the normal expenses incurred for treatment of cancer in a clinical trial situation, they would uniformly answer no."

That kind of attitude led to the difficulty experienced by the California insurer, Dr. Taylor continued. In Illinois, most patients have not questioned insurance companies about this issue; they just pay for the treatment themselves, or don't have it, he added.

AS REPORTED IN the *National Law Journal*, the plaintiff in the California case was diagnosed with breast cancer in June 1991. After that, she underwent two modified radical mastectomies followed by chemotherapy. By fall 1991, the cancer was discovered in the plaintiff's bone marrow. Early the next year, her physician estimated that she had five to eight months to live but suggested that a bone marrow transplant might prolong her life. After six weeks of testing, she was determined to be a good candidate for the transplant. But her HMO denied coverage on the grounds that bone marrow transplantation was an "experimental" treatment and therefore not covered under her health plan.

The plaintiff sued her insurer, claiming bad faith, breach of contract and intentional infliction of emotional distress. The plaintiff's family was able to raise enough money to pay for the procedure, and the transplant was performed in August 1992. The plaintiff subsequently died, but her husband continued the lawsuit.

On Dec. 23, 1993, the jury awarded \$12.32 million in compensatory damages and later added \$77 million in punitive

damages.

"The bottom line is that the jury gave us the number, and that is the vehicle for the message that when you market a [health] plan and entice people with your services, when they get sick you have to provide those services," said Mark O. Hiepler, the plaintiff's attorney and brother. Bone marrow transplantation was a specifically covered benefit of the plan, he added. However, he alleged that the insurer offered its employees financial incentives to deny claims for expensive treatments. The insurance company could not be reached for comment.

THERE ARE SEVERAL circumstances under which a physician might suggest a bone marrow trans-

plant, said Dr. Gordon. After undergoing surgery for a high-risk cancer, a patient might receive only chemotherapy, or the physician might suggest chemotherapy followed by a bone marrow transplant. Patients who have experienced recurrent breast cancer that was either surgically removed or treated with radiation and who still have a high chance of another recurrence might also undergo the transplant. In addition, physicians whose patients suffer from metastatic disease that is unresponsive to chemotherapy might suggest a bone marrow transplant in hope of getting a better response, he noted.

"I think that health care reform is going to require

guidelines for standards of care, and I think that that is going to put an onus on the medical profession to document which treatment does what," said Dr. Taylor. "I don't think that we have documented sufficiently at the present time whether bone marrow transplants save lives or prolong survival, and that is the major limitation on defining it as a procedure today."

"Because clinical trials have not been established to assess whether the transplants save lives or shorten survival—which is a very real possibility with bone marrow transplants—the public really has nothing to go on but a lot of emotionalism, and the insurance industry is suffering the consequences," Dr. Taylor said. ■

MALPRACTICE ROUNDUP

Product liability reforms necessary, study says

Medical Liability Monitor reports that a recent study conducted by the Rand Corp. Institute for Civil Justice revealed that the threat of liability and the financial consequences of liability may deter drug and medical device makers from developing new products. Among the products discussed were AIDS vaccines, drugs to treat pregnancy-related conditions and live-virus vaccines. According to the study, however, the potential for a "blockbuster" drug—such as Prozac—that could generate significant profits can outweigh liability concerns for other types of products.

According to the study's author, product liability reforms are necessary to help level the playing field. He suggests that liability for manufacturers' defective design or failure to warn about potential side effects should be limited to injuries that result from a company's failure to comply with relevant U.S. Food and Drug Administration regulations. He recommended that explicit standards be specified for behavior that warrants punitive damages. In addition, he said court-appointed witnesses or science panels should be used to consider the scientific evidence relating to the cause of individuals' injuries. ■

Duty of care extends to independent medical exams

The Colorado Supreme Court held that a physician performing an independent medical exam must act with reasonable care when referring a patient for further testing. In *Greenberg vs. Perkins*, a doctor was retained to examine the plaintiff to determine the extent of injuries she had suffered in a car accident. He then referred her for a functional capacity evaluation even though he knew she had experienced back problems and back surgeries. The plaintiff subsequently required surgery to alleviate the back pain she experienced after the evaluation.

A trial court ruled that the defendant did not owe a duty of care to the plaintiff, because there was no prior physician-patient relationship.

The Supreme Court, however, extended the duty of care concept—that an examination of a nonpatient must be conducted in a way that does not cause harm—to include referrals of nonpatients for further testing with another provider.

Since the doctor knew about the plaintiff's back problems, the jury found that the benefit of further testing was outweighed by the potential for injury. ■

THE CHANGING MARKETPLACE

ISMS talks reform at CMS Midwest Clinical Conference

Speakers help attendees understand the current realities and options.

BY KATHLEEN FURORE

The financing and delivery of health care in this country are going to change. That is undeniable. But exactly which changes will occur and how they will affect practicing physicians are still being debated, as those who will be most influenced by reform scramble to place vital issues on the agenda.

To help doctors better comprehend the rapidly changing health care environment and the legislative action taking place, ISMS presented the seminar "ISMS in Transition: The Impact of Health Reform in the Medical Marketplace" on Feb. 11 during the Chicago Medical Society Midwest Clinical Conference. Speaking before an attentive audience were ISMS President Arthur R. Traugott, MD; ISMS President-elect Alan M. Roman, MD; ISMS Third District trustee M. LeRoy Sprang, MD; and Chicago Medical Society President-elect John F. Schneider, MD. The speakers provided overviews of the Clinton, Cooper and McDermott plans; updated participants on ISMS' efforts to inform Society members and their patients about health care reform; and discussed ways the organization is striving to influence key policy issues that affect physicians and their patients at the state and local levels.

Regardless of the specific topic, the overall message was the same: Medical professionals must accept that change will occur, do all they can to ensure that patients receive optimal care at a fair price and fight to include antitrust relief and caps on noneconomic damages in any reform package passed.

"Everything is changing so rapidly that we have to change our own thinking and recognize there are forces over which we have no control," said Dr. Traugott. "There are six proposals [being considered], with varying degrees of good features. What we need to do is discover a way to keep the delivery of health services physician-directed and keep Illinois physicians involved with reform."

To inform seminar attendees about the nuances of the most talked-about health care proposals, Dr. Traugott reviewed the Clinton, Cooper and McDermott plans, explaining ISMS' position on each one. According to Dr. Traugott, the president's proposal includes some of the same basic goals as the Society's policy, but it is too difficult and costly to implement. "Clinton's plan promises universal access to a good package of benefits and promises to deliver care at attractive prices, but there are several practical difficulties. The financing is inadequate, it will be expensive for business, and rationing will result and become more severe over time."

Dr. Traugott also criticized the plan's reliance on a national health board, which would exercise authority over all aspects of the new system. In addition, he expressed concern about its focus on large purchasing cooperatives, which would control the market, and its omission of antitrust relief and caps on noneconomic damages.

"If we're to negotiate and compete, we need antitrust relief for doctors that allows us to form networks, so that we're not guilty of collusion and price-fixing," continued Dr. Traugott. "And the malpractice reform issues [in Clinton's plan] fall far short. In Illinois, we already have most of the provisions called for, and there are no caps on noneconomic damages, which are necessary for reform."

The Cooper plan, comparatively, is a middle-of-the-road alternative, said Dr. Traugott, noting that it is based on competition and rejects stringent government controls. It guarantees access to high-quality, affordable health care for everyone, eliminates pre-existing condition limitations, provides subsidies for low-income patients and limits noneconomic damages to \$250,000 – all issues ISMS considers vital to successful health care reform. What it doesn't do, added Dr. Traugott, is create massive health care delivery systems

THE CHANGING MARKETPLACE

regulated by an even more massive bureaucracy.

"Whenever a program is government-imposed, it becomes an entitlement program and impervious to change," Dr. Traugott observed, citing Medicare as one example. "The Cooper plan encourages provider-payer partnerships similar to those proposed in the Clinton plan, but the partnerships could be much smaller. There would be oversight, not regulatory authority."

Dr. Traugott next touched on the McDermott plan (also referred to as H.R. 1200 or the single-payer plan). He pointed out that it contains no tort reform or antitrust reforms and would drastically raise taxes.

ALSO PRESENTED during the four-hour seminar were updates on progress made by ISMS' Subcommittee on Public Relations/Health Reform Proposals, Washington Presence program and Medical Leadership Initiative. Dr. Roman noted that the subcommittee's theme, Health Reform: Taking Charge of Change, is being carried statewide by outreach efforts that include ongoing regional speaker training sessions to brief members on current health system reform proposals and the Society's response. Other activities are an all-physician mailing featuring ISMS' comprehensive analysis of the Clinton plan, a recently completed socioeconomic survey to help ISMS understand what kind of health reform initiatives will best serve members, a patient information kit now being distributed to physicians and their patients, and town meetings that bring doctors and patients together to discuss health care reform.

"We want to help physicians and patients cut through the jargon, and we want to spread ISMS' message on health care reform," Dr. Roman explained, stressing that the subcommittee will offer speaker training to all members who want to do outreach in their communities. "The subcommittee continues to work aggressively, because the system as we know it is gone, and we want to be sure the system we get doesn't compromise the quality of care. We ardently believe in and wish to be part of the process to embrace change. And you, as physicians, have a unique opportunity to help us communicate our message."

Turning to the Washington Presence program, Dr. Sprang reiterated the importance of physician involvement in influencing health care legislation at the national level. He encouraged participation in grass-roots lobbying efforts, asking physicians and their patients to contact their U.S. representatives and senators about reform issues of concern to them. And he emphasized the program's key objective – "to persuade as many members of the Illinois congressional delegation as possible to

vote for a health care reform plan acceptable to Illinois physicians." That final plan, he said, "must include antitrust and tort reform, to level the playing field and reduce the risk of reducing the quality of patient care."

Returning to the podium, Dr. Traugott discussed recent actions taken by the ISMS Board of Trustees as part of the Medical Leadership Initiative. Specifically, the board is studying the feasibility of forming a physician network, PPO, clinic without walls, IPA or HMO, and exploring services ISMS can offer to help members meet the new challenges presented by integrated managed care, he noted. "We need to find out from you what is needed – what is going on in your area."

Finally, Dr. Schneider spoke of the dangers when nonphysicians create practice parameters like those Blue Cross and Blue Shield of Illinois recently imposed on members of its managed care network for certain specialties.

Practice parameters must be guidelines and nothing more, Dr. Schneider explained. "They can provide a useful foundation for physicians in making certain clinical decisions. However, they are an aid to clinical decision making, not a replacement for physician judgment or experience." ■



Photos by Brian Warling



Participants in the CMS Midwest Clinical Conference include (clockwise from top) guest speaker Gov. Jim Edgar; IMPAC member Edmund R. Donahue Jr., MD; Dr. Roman and Dr. Traugott.

Practice guidelines

(Continued from page 1)

ment, according to Blues officials.

The Society's apprehension centered on guideline content, the potential impact on patient care and the perceived lack of broad-based input. Communication between the groups led to the joint goals of gaining medical credence and acceptance of the guidelines and building physician understanding about appropriate guideline use by the Blues and other insurers and payers, Dr. Freidheim said.

Discussion about this issue will be ongoing, and ISMS will participate in the Blues' continuing guideline review and refinement, Dr. Freidheim said. In addition, ISMS leadership and Blues officials will meet at least twice a year to promote continuing cooperation and dialogue.

"These new steps will greatly benefit [Blues] customers in Illinois," said C. Jonathan Shattuck, Blues senior vice president. "Our accountability to our customers is founded upon our ability to bring high-quality, cost-effective care to patients throughout Illinois."

"We are enlisting ISMS in our efforts to educate the medical community on that mission, as well as gaining the broad-based clinical expertise of ISMS members in our quality assurance process," Shattuck continued. "We firmly believe that this will serve Illinois patients and physicians well in an era of health reform and better promote cost-effective medical care."

Dr. Widen stressed that the guidelines represent the best medical thinking of the time and will be constantly reviewed and revised. "The guidelines are not immutable," he said. "They are developed by physicians and should be taken very seriously by physicians." However, he noted that each case is different and that the Blues will tolerate appropriate deviation from the guidelines.

In the letter to members, Dr. Freidheim outlined several aspects of the agreement that resulted from the January meeting, including the following:

- ISMS representation on the Blues' Quality Standards and Studies Committee, which is responsible for developing and refining practice guidelines;
- Blues representation on an ISMS committee to respond to physician concerns about quality of care issues;
- Regular meetings between ISMS and the Blues to maintain open communication about quality issues affecting Illinois physicians and their patients; and
- Concordance between ISMS and the Blues that they will notify each other before making public announcements regarding major quality-related initiatives affecting Illinois physicians.

"Both [the Blues] and ISMS look forward to a newfound spirit of cooperation in the future, as well as a robust exchange of viewpoints," Dr. Freidheim wrote. "We believe that this cooperation and exchange hold great promise for maximizing health care quality and minimizing health care costs for Illinois patients." ■

Reimbursement

(Continued from page 1)

Burris rendered his opinion in response to a request from state Rep. David Phelps (D-Eldorado), chairman of the Illinois House of Representatives' Health Care and Human Services Committee. In the opinion, Burris noted that the Illinois Nursing Act provides for the licensure of registered nurses but does not provide for licensure of specific nursing specialties.

Physicians are licensed equally under the Medical Practice Act, but not by specialty, Dr. Traugott said. He added that the ISMS House of Delegates adopted policy more than a decade ago opposing the licensure of any new health care professional categories, such as specific licenses for nurse specialists. Such licensure leads to independent reimbursement, which in turn increases the cost of health care delivery by adding another layer of care, he explained.

Although nurses with advanced degrees can carry out some functions — such as conducting health screenings and well-baby exams and providing follow-up care to physician visits — those functions do not include the practice of medicine, Dr. Traugott stressed. In Illinois, nurse practitioners do not have any prescriptive authority and cannot make

diagnoses, he noted.

"Physicians are the only medical professionals who can diagnose, as identified under Illinois law," Dr. Traugott said. "Prescription of medication is determined after the physician establishes a medical diagnosis and develops a medical treatment plan. Prescribing medications is an integral part of that plan. Therefore, prescribing medications must be done only by physicians, since they alone have acquired the necessary experience through training and education."

Nurse specialists are a vital part of a coordinated health care team, but physicians must be the team captains, Dr. Traugott said. "We continue to support the valued contributions of nurse practitioners. But our patients deserve the confidence of knowing that decisions about their health care are made by a

skilled and qualified physician who brings to the task solid and extensive medical education and experience."

As the nation moves toward health system reform and a managed care delivery system, health care professionals should renew their commitment to collaborate in providing top-quality medical care, Dr. Traugott said. "The focus must shift to an increasingly cooperative relationship that fosters the best possible patient care." ■

Prescribing medications must be done only by physicians, since they alone have acquired the necessary experience through training and education.



Matt Ferguson

U.S. REP. J. DENNIS HASTERT (center) discusses health care reform with Norbert M. Becker, MD (left), and Gary V. Rubin, MD, during the Illinois Association of Ophthalmology's annual legislative dinner held last month in Oak Brook. More than 30 state lawmakers and about 130 physicians attended the event.

IDPR DISCIPLINES

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

November 1993

Kenneth Davis, Chicago — physician and surgeon license indefinitely suspended after practicing on a non-renewed license.

Anthony Peter Dalton, Dixon — physician and surgeon license issued on probation for six years; controlled substance license issued on probation for six years due to a substance abuse problem.

James Hawk, Danville — physician and surgeon license issued on indefinite probation after being disciplined in the State of California and the State of Indiana.

William H. Shackelford, Arthur — physician and surgeon license placed on indefinite probation for a minimum of two years; controlled substance license indefinitely suspended for a minimum of five years after prescribing controlled substances without a valid controlled substance license.

John Simpson, Clayton, MO — controlled substance license placed on probation for six months after prescribing large quantities of controlled substances to his wife.

Robert E. Vigasaa, Norton — physician and surgeon license placed on indefinite probation for a minimum of three years due to an alleged mental impairment, to wit, compulsive gambling.

Jack Wolper, Quincy, MA — physician and surgeon license placed on probation until October 1994, after being disciplined in the State of Massachusetts.

December 1993

Charles Dickens, Los Angeles, CA — temporary medical license issued on indefinite probation due to a substance abuse problem.

Yogesh Gandhi, Chicago — physician and surgeon license placed on indefinite probation for a minimum of five years after being disciplined in the State of Wisconsin.

Rose Gorday, Chicago — physician and surgeon license indefinitely suspended after being declared incompetent in the Circuit Court of Cook County.

Ajita V. Kasbekar, Burr Ridge — physician and surgeon license placed on probation for three years and fined \$5,000 after allegedly billing a patient for anesthesia services that were not rendered and failing to possess a controlled substance license.

Herbert Paul, Richton Park — physician and surgeon license and controlled substance license revoked due to dishonorable, unethical and unprofessional conduct.

January 1994

James E. Beckett, Des Plaines — controlled substance license issued on probation for twenty-one years after respondent answered affirmatively to a personal history question on his application for licensure.

Martha Hernandez, Chicago — physician and surgeon license indefinitely suspended after violating a previous Department ordered probation.

Woo Young Kim, Sterling — physician and surgeon license reprimanded after allegedly prescribing for non-therapeutic purposes.

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Glenview: Medical/surgical office for sublet. Furnished/decorated three years ago. Near Glenbrook Hospital. (708) 657-9292.

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RxWriter: Professional prescription-writing software for your PC. Makes prescription writing fast, accurate and legible. Many exclusive features. Easy to learn and use. \$185. Hall Design, 250 Maple Ave., Wilmette, IL 60091; (312) 337-1611.

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Transcription service: 8.5 cents per line, phone-in dictation, messenger service, 24-hour service. Excellent references. Lee-Perfect Transcribing, (312) 664-1877.

"Depression Throughout the Lifespan: Psychopharmacologic and Psychotherapeutic Strategies," featuring Steven Dubovsky, MD; R. Taylor Segraves, MD, PhD; George Zubenko, MD, PhD; and Walter Menninger, MD; June 24-25. Location: Kansas City. CME credit: 12 hours. Cost: \$195. Contact Menninger Continuing Education, (800) 288-7377.

"Medical Marriages: Balancing Commitments to Family and Profession," featuring Roy Menninger, MD, and Bev Menninger, July 24-29, Crested Butte, Colo. CE credit: 24 hours. Contact Menninger Continuing Education, (800) 288-7377.

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New campaign highlights safe medication use

[WASHINGTON] "Will this new medicine work safely with the other prescription and nonprescription medicines I am taking?" That's the question actor Ed Asner will be encouraging patients to ask their physicians and pharmacists in an upcoming series of national television, radio and print public service ads. The campaign is scheduled to begin in the spring and is sponsored by the National Council on Patient Information and Education and the U.S. Administration on Aging.

Once the ads begin airing, physicians and pharmacists should be prepared to answer that question, said Robert M. Bachman, executive director of the council. "Improving communication between health professionals and their patients about multiple medicine use is crucial.

"More than 23 million Americans age 65 and older take, on average, between one and six or more prescription medicines per day," Bachman continued. "Each year, older patients experience more than 9 million adverse reactions, and a fourth of all nursing home admissions result from older persons' inability to take their medicines properly. Urging patients to ask if their new prescription will work safely with the other medicines they are taking is a major step in reducing the avoidable health problems that can occur with multiple medicine use."

Bachman added that it is equally important for doctors, pharmacists and other health professionals to routinely review the medications their patients are taking before prescribing any new drugs.

Rehab Institute receives \$100,000 safety grant for Injury Prevention Program

[CHICAGO] The Rehabilitation Institute of Chicago received a \$100,000 safety grant in December from the National Highway Traffic Safety Administration/U.S. Department of Transportation. The grant, which will be administered by the Illinois Department of Transportation, will help fund the Rehab Institute's Injury Prevention Program. The facility's Women's Board has pledged to contribute an additional \$57,000 for the program.

"Injuries are the leading killer of young people, and motor vehicle collisions are the No. 1 cause of spinal cord and brain injuries," said Henry B. Betts, MD, Rehab Institute medical director. According to the institute, individuals age 15 to 24 are at highest risk for experiencing these types of injuries.

The grant will fund the Think First program, which is part of the institute's overall injury prevention efforts. The program is designed to educate junior high and high school students about risk-taking behaviors — like drunken driving — that can result in brain and spinal cord injuries. As part of the program, a young person who sustained a traumatic injury gives a classroom presentation about how that injury affected his or her life.

The grant will also fund a public information and education campaign about how using safety belts, child safety seats and bicycle and motorcycle helmets can reduce preventable injuries and fatalities, said Gary March, director of IDOT's division of traffic safety.

FTC opinion

(Continued from page 1)

cantly above usual and customary," said CMS President Sandra F. Olson, MD. "We received many complaints about the individual for excessive, egregious charging." The physician appeared before the CMS Fee Mediation Committee, but the charging practices were never changed, she said. "We had no power to do anything, because it was an economic issue, not a quality of care issue."

According to CMS officials, the FTC opinion allows medical societies to conduct peer review related to fees and discipline physicians for excessive charging in connection with fraud or other abuse.

"Advisory peer review can give patients and payers information about the basis for a fee and an informed opinion about its reasonableness and help them decide whether to pay a disputed bill or to continue to patronize a particular doctor," the FTC said in a letter to the two organizations. "In cases where the fee charged arose from abusive behavior, professional discipline may also improve the functioning of the market by deterring such behavior." The FTC cautioned, however, that disciplining physicians for excessive charging that is unrelated to fraud or other law violations could violate antitrust laws and injure consumers.

The commission's opinion increases the medical profession's ability to police itself in areas where the public's best interest might not be served.

"We are not concerned with the commission's limitation of its support to fee practices that involve fraud, abuse or other inappropriate exploitative behavior," Johnson said. "Although we had indicated [in the proposal] that a fee as low as 50 percent above the usual fee could be the subject of a discipline, we made clear our intent to focus on fees 'so high as to border on fraud.' Our program would permit as a defense that the patient was fully informed and competent."

The AMA-CMS proposal further requested that medical societies be permitted to publish names of disciplined physicians but not the amount they had charged. According to the FTC ruling, this practice would not endanger competition, provided no antitrust laws were violated. The FTC also said that mandatory physician participation in advisory fee review is "reasonably related" to making information about fees available to consumers and is not likely to threaten competition.

The commission's opinion "increases the medical profession's ability to police itself in areas where the public's best interest might not be served," Dr. Olson said. "Economic issues are becoming more significant for physicians as the medical climate is changing. We are very pleased with the decision. It will only be a public benefit."

OBITUARIES

* Indicates member of ISMS Fifty Year Club

*Berger

Edward M. Berger, MD, a general practitioner from Northbrook, died Jan. 9, 1994, at the age of 92. Dr. Berger was a 1925 graduate of the Loyola University Stritch School of Medicine, Maywood.

Bobowski

Stanley J. Bobowski, MD, a pathologist from Champaign, died Feb. 2, 1994, at the age of 65. Dr. Bobowski was a 1954 graduate of the University of Manitoba Faculty of Medicine, Winnipeg.

Busch

Anthony K. Busch, MD, a psychiatrist from Belleville, died Oct. 29, 1993, at the age of 87. Dr. Busch was a 1937 graduate of the St. Louis University School of Medicine.

*Clark

Alvin H. Clark, MD, a general practitioner from Winfield, died Oct. 11, 1993, at the age of 94. Dr. Clark was a 1931 graduate of the University of Illinois College of Medicine, Chicago.

*Giunta

Edward J. Giunta, MD, an occupational physician from Peoria, died Jan. 22, 1994, at the age of 79. Dr. Giunta was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

Goldinger

James M. Goldinger, MD, an internist from Chicago, died Oct. 12, 1993, at the age of 76. Dr. Goldinger was a 1941 graduate of the Pritzker School of Medicine of the University of Chicago.

*Gustin

Karl S. Gustin, MD, a general practitioner from Altoona, Fla. (formerly of Chicago), died Jan. 4, 1994, at the age of 91. Dr. Gustin was a 1928 graduate of the Loyola University Stritch School of Medicine, Maywood.

Hovde
Rieber C. Hovde, MD, a general practitioner from Normal, died Oct. 24, 1993, at the age of 81. Dr. Hovde was a 1939 graduate of Northwestern University Medical School, Chicago.

Howard

Ernest B. Howard, MD, a dermatologist from Barrington, died Oct. 22, 1993, at the age of 83. Dr. Howard was a 1936 graduate of Boston University School of Medicine.

Keller

Otto J. Keller, MD, a general practitioner from Chicago, died Oct. 16, 1993, at the age of 86. Dr. Keller was a 1935 graduate of the Universitaet Wien, Medizinische Fakultae, Wien, Austria.

*Merar

Thomas J. Merar, MD, a colon and rectal surgeon from Highland Park, died Jan. 10, 1994, at the age of 88. Dr. Merar was a 1930 graduate of Northwestern University Medical School, Chicago.

Michels

Donald G. Michels, MD, an orthopedic surgeon from Hinsdale, died Oct. 22, 1993, at the age of 72. Dr. Michels was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

Mueller

Byron I. Mueller, MD, a general practitioner from LaHarpe, died Nov. 2, 1993, at the age of 83. Dr. Mueller was a 1934 graduate of the University of

Iowa College of Medicine, Iowa City.

Otto

Claude W. Otto, MD, an Ob/Gyn from Frankfort, died Oct. 5, 1993, at the age of 78. Dr. Otto was a 1942 graduate of the University of Nebraska College of Medicine, Omaha.

*Palmer

Walter L. Palmer, MD, a gastroenterologist from Chicago, died Oct. 28, 1993, at the age of 97. Dr. Palmer was a 1922 graduate of Rush Medical College, Chicago.

Podmajersky

Paul Podmajersky, MD, a general practitioner from Roseburg, Ore. (formerly of Chicago), died Oct. 12, 1993, at the age of 76. Dr. Podmajersky was a 1948 graduate of the University of Colorado School of Medicine, Denver.

Roller

Wendell F. Roller, MD, a general practitioner from Monmouth, died Feb. 24, 1994, at the age of 79. Dr. Roller was a 1942 graduate of the University of Kansas School of Medicine, Lawrence-Kansas City.

*Shalla

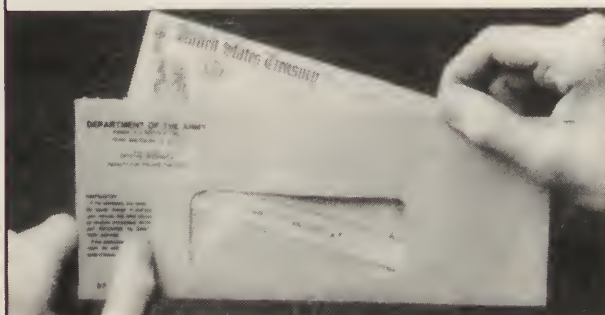
Leon S. Shalla, MD, a general practitioner from Downers Grove, died Jan. 18, 1994, at the age of 92. Dr. Shalla was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

Stockdale

Earl M. Stockdale, MD, a pediatrician from Rock Island, died Feb. 7, 1994, at the age of 67. Dr. Stockdale was a 1953 graduate of the Jefferson Medical College of Thomas Jefferson University, Philadelphia.

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ON FOR 'GOOD SAMARITAN' PHYSICIANS (PAGE 8)

Chicago physicians meet with President Clinton

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Illinois Medicine

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Cardiac care
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PAGE 10



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After Chicago high school students presented their ideas for reforming the Medicaid system during a Feb. 7 program, Chicago Health Commissioner Sister Sheila Lyne (second from left) and U.S. Rep. Dan Rostenkowski (center) discussed the pros and cons of the Clinton plan.

High school students debate reform issues

HEALTH CARE FORUM: A Chicago hospital elicits ideas from future leaders. By Anna Chapman

[CHICAGO] Students from four Chicago high schools participated in a health care forum Feb. 7 at Columbus-Cabrini Medical Center to debate how the Clinton plan would affect the Illinois Medicaid system. Pairs of students from Curie, Lincoln Park and Lane Technical high schools and the Kenwood Academy took opposing positions on the issues of universal access to care, funding, cost containment and patients' rights and responsibilities.

The students presented their ideas to more than 100 hospital CEOs, elected officials and community, business and civic leaders. Columbus-Cabrini sponsored the program, which was moderated by WBBM-TV news

anchorperson Bill Kurtis.

"Some of the effects of health care reform may be felt immediately, but it may be years before we feel the full impact," said Lee Domanico, Columbus-Cabrini chief executive officer, introducing the program. "This is why we've asked high school students, as the next generation, to voice their viewpoints and ideas about reform. Their lives may be affected by reform even more than ours."

Calling the Clinton plan commendable but impractical, Phyllis Son, a Lincoln Park senior, said she believes in nationalization of health care. An income tax increase would be necessary to accomplish this, she said.

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Governor calls for Medicaid overhaul

BUDGET: The governor's fiscal 1995 budget proposal contains increases for health-related programs. By Anna Chapman

[SPRINGFIELD] In his March 2 budget address to the General Assembly, Gov. Jim Edgar promised to overhaul the state's Medicaid system by expanding managed care, targeting fraud and abuse, and requiring prompt reimbursement to providers. Edgar's proposed \$31.5-billion fiscal 1995 budget is 4.2 percent higher than this year's budget. The governor also renewed his vow to hold the line on taxes.

"This budget invests in Illi-

nois and helps the people of Illinois invest in themselves," Edgar told the legislature.

Calling the cost of Medicaid one of the top fiscal concerns of U.S. governors, Edgar said the state would implement cost-containment programs that have proved successful for many large businesses.

"Illinois cannot - and should not - wait any longer for national health care reform or a change in the ways of the Unit-

(Continued on page 15)

Women's health forum highlights concerns

TOWN MEETING: Groups testify on health issues affecting women. By Anna Chapman

[CHICAGO] Testimony presented during a Feb. 2 town meeting indicated that women's health issues are diverse, ranging from smoking and breast and cervical cancer to violence against women. Representatives of about 20 groups, including ISMS, testified during the day-long session in Chicago.

Sponsored by the Illinois Department of Public Health and the U.S. Department of Health and Human Services, the meeting was part of the U.S. Public Health Service's effort to discern women's health needs, said Edith Sternberg of IDPH's health promotion division. Illinois is the first state to hold such a meeting; similar pro-



Dr. Olson

grams are scheduled in Indiana, Michigan, Minnesota, Ohio and Wisconsin.

"The purpose of the meeting is to allow people to bring to our attention what they feel are women's health issues in Illinois, women's health needs [and] the strengths and weaknesses in the state's current system," Sternberg said.

"We want to use that information to determine whether we are targeting the right priorities [and] whether there are other issues we need to look at."

Representing ISMS, Sandra F. Olson, MD, an ISMS Third District trustee and president of the Chicago Medical Society, pre-

(Continued on page 14)

Incumbents score election wins



In a primary election marked by a light turnout statewide, Illinois voters set the stage on March 15 for November's general election. Leading the fall slate will be Gov. Jim Edgar, who garnered 75 percent of

the Republican vote in beating challenger Jack Roeser. Edgar will face the Democratic nominee, Illinois Comptroller Dawn Clark Netsch, who defeated Attorney General Roland Burris and Cook County Board President Richard Phelan. Voters selected state Sen. Penny Severns (D-Decatur) as Netsch's

running mate. Running unopposed in the primary, Lt. Gov. Bob Kustra secured the GOP slot for that office on the November ballot.

In other statewide races, Republican Secretary of State George Ryan did not face a primary challenge. He will oppose Patrick Quinn, the state treasurer, in the general election.

In the contest for attorney general, DuPage County State's Attorney Jim Ryan beat Metra chairman Jeff Ladd in the GOP primary. Ryan will run against trial lawyer Albert Hofeld, who won the Democratic nomination. Republican state Sen. Judy Baar Topinka (R-North

(Continued on page 14)

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Courtesy of Schwab Rehabilitation Hospital

PRESIDENT CLINTON talks about health care with **Richard Lazar, MD**, executive vice president and medical director of **Schwab Rehabilitation Hospital and Care Network (center)**, and **Leslie Zun, MD**, chairman of emergency medicine at **Mt. Sinai Hospital Medical Center**. The physicians participated in the Feb. 28 roundtable discussion convened in Chicago by the White House to address crime-related health costs.

Chicago physicians meet with President Clinton

VIOLENCE: Area health care providers share their views on the cost of gun-related injuries. By Kathleen Furore.

[CHICAGO] President Clinton brought the national health care debate to Chicago last month by conducting a roundtable discussion with local trauma and rehabilitation providers on the effects of gun violence and crime on U.S. health care. About 40 people – including 24 physicians and nurses, Chicago Mayor Richard M. Daley, law enforcement officials and victims of violence – participated in the one-hour dialogue Feb. 28 at Wright Jr. College on the city's northwest side.

The White House decided to conduct the roundtable after reading news accounts of a Feb. 23 news conference at Mt. Sinai Hospital Medical Center about the relationship between crime and rising health care costs, said one of the event's organizers, Mark Karlin, vice president of marketing and business development at Schwab Rehabilitation Hospital and Care Network. White House staff called the facility on Friday, Feb. 25, to arrange the roundtable for the following Monday. "They didn't want people involved in policy, but people who work in the trenches treating victims of violence," he explained. "We were able to get 24 physicians and nurses from trauma and rehab centers in the city and suburbs. And they were people working in the trenches." In fact, several individuals had been treating gunshot patients when they were called to participate in the roundtable, he noted.

The president began the event with a phone call to congratulate Jim and Sarah Brady about the passage of the Brady Bill. He then started the roundtable discussion. Seated at the table with Clinton was Mindy Statter, MD, director of pediatric trauma at the University of Chicago Medical Center and a pediatric surgeon at Wyler Children's Hospital.

Dr. Statter said the president asked her about the demographics of the patients she treats and whether she sees more children with multiple gunshot wounds because assault weapons are so readily available. "I told him that about 10 percent of the 500 trauma admissions I treat [annually] suffer gunshot wounds and that of that 10 percent, 80 percent are black males under the age of 15," she said, noting that in 1992 and 1993 more than 10 patients she treated died from gunshot injuries. "I also told him I was seeing a lot of children shot at close range in classrooms with handguns and

that with pediatric patients, a single shot at close range can be just as fatal as multiple shots with assault weapons."

Dr. Statter said she also told the president about the long-term impact gun violence has on society. "I explained that children who are maimed or severely injured can be lost from the work force and never reach their potential. And even those who are just grazed may not perform well in school, which means their potential also is affected. It impacts greatly on their future."

During the exchange, Clinton addressed every aspect of violence, Dr. Statter said. "He asked how neighborhoods could be policed more effectively, talked about after-school programs and discussed the social, ethical and moral aspects of violence. He really incorporated information from people around the room and at the table." ■

Illinois med student, resident receive awards

[CHICAGO] William D. King, a medical student at the University of Illinois at Urbana-Champaign, and Sam L. Page, MD, a resident at Northwestern Memorial Hospital in Chicago, have won 1994 AMA/Glaxo Achievement Awards. The annual awards, funded by Glaxo Inc., are presented to 25 medical students and 25 residents or fellows nationwide in recognition of exceptional nonclinical leadership skills.

A delegate to the AMA-Resident Physician Section, Dr. Page has participated in the AMA-Medical Student Services Government Relations Internship program and attended the American Medical Political Action Committee Campaign Management School. He applied his government relations education while working on the successful reelection campaign for his congressional representative Joan Kelly Horn. While attending medical school at the University of Missouri-Kansas City, Dr. Page also served as a member of the Missouri State Medical Association's Legislative Committee.

King, an MD-JD candidate at the University of Illinois, has lectured on community and minority health issues to junior high and college students. He also established a special populations liaison committee to the university's student health center. According to King, the committee was formed as an outreach and education program that teaches student representatives to be health advocates and educates the health center about minority and disabled students' health care problems and concerns. In addition, King serves as a board member of a community health center and has mentored pre-med and other students. He has also organized conferences addressing health care access issues and

is currently conducting research on improving access for medically underserved Los Angeles residents.

Dr. Page and King each received a \$900 stipend as part of the award, to help pay the expenses they incurred while attending the AMA National Leadership Conference in San Francisco in February. ■

Wrigley Field, McDonald's go smoke-free

[CHICAGO] Season ticket holders were the first to learn the news: Fans attending baseball games at Wrigley Field can no longer smoke in the stands. In a letter to ticket purchasers, Chicago Cubs management announced that beginning this spring, the seating areas in Wrigley Field will be smoke-free.

Patrons will be allowed to smoke only in the ramp and concourse areas starting opening day, April 4, said Mark McGuire, Cubs executive vice president of business operations. Smoking has been banned in the press box and the Wrigley Field offices for several seasons, he noted.

"This is an entertainment business," McGuire said. "It's hard to justify selling people a seat when they are subjected to something they find so objectionable." Most baseball fans do not smoke, he added. "We are also aware of the serious health risk [of smoking]."

During the 1993 season, the Cubs organization made announcements over the public address system encouraging smokers to consider other fans seated around them, McGuire said. "But we didn't feel this was enough." In addition, the team conducted surveys at the park to determine fan sentiment on the issue.

McGuire said he believed a smoking ban was inevitable and added that management thought it was the "right thing to do."

Baseball isn't the only industry implementing no-smoking policies for its patrons. McDonald's Corp. announced Feb. 23 that smoking is now prohibited in its more than 1,400 company-owned restaurants throughout the United States.

"We're doing this because we believe it's the right thing to do for our customers and our employees," said Ed Rensi, president and chief executive officer of McDonald's USA. "We also continue to actively encourage our franchisees to make their restaurants smoke-free, and more are voluntarily doing so every day."

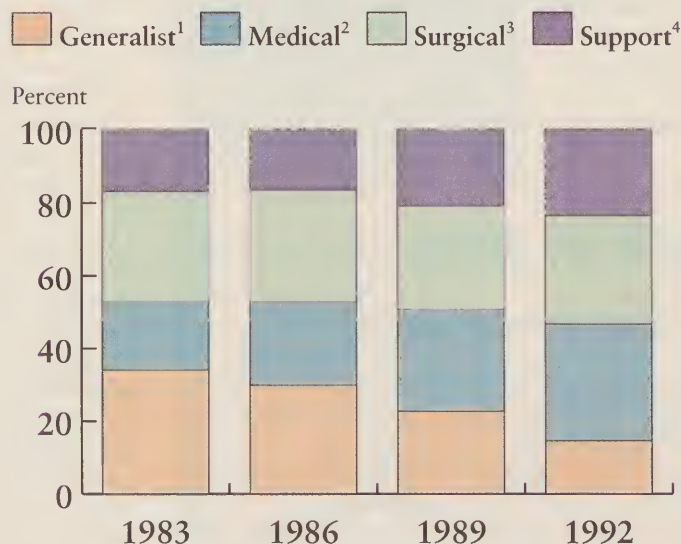
By the end of 1993, more than 2,200 McDonald's restaurants had already voluntarily banned smoking, according to company officials. ■

PHYSICIAN FACTS



More grads specializing

The following shows the percentage of graduates choosing various specialties:



¹ Family practice, general internal medicine, general pediatrics

² Psychiatry, allergy, dermatology

³ General surgery, gynecology, orthopedic surgery, plastic surgery

⁴ Anesthesiology, pathology, radiology

Source: 1982-92 Association of American Medical Colleges Medical School Graduation Questionnaire

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Partnership links Cook County clinics

ACCESS: A new referral system enables patients to receive care at community health centers.

By Kathleen Furore

[CHICAGO] Hospital emergency rooms and walk-in clinics throughout the state are often filled with medically underserved patients seeking nonemergency care. But that situation is improving at Cook County Hospital because of an innovative partnership between the hospital and two community-based clinics.

The Physician Referral and Linkage Project, designed to increase access to medical services and enhance coordination of care, enables the hospital to refer adult patients from its overburdened Fantus Health Center to the Alivio Medical Center and Bethel Wholistic Health Center. In turn, the project facilitates patient referrals from these community centers into the hospital's subspecialty clinics when necessary, according to program officials.

PATIENTS RECEIVE the benefit of an ongoing physician-patient relationship, since the partnership was devised to allow patients to see the same physicians at the hospital and at their local centers whenever possible. Currently, two family physicians divide their time between the hospital and the community health centers.

"Our goals are to increase the capacity [for treating patients] at the community centers and get patients out of emergency rooms and walk-in clinics, to build relationships between providers at the health centers and Cook County, and to create a computerized referral and information system so that the health centers and the hospital can communicate electronically," said David Ansell, MD, chairman of Cook County Hospital's division of general medicine/primary care.

He noted that before the program's inception in September 1993, little communication existed between the hospital and community clinics. "We at County didn't necessarily know what the community clinics were doing, so we didn't refer our patients. And if the community centers needed to send patients for special tests, they gave them a slip of paper and sent them to Cook County, where they'd wait hours in the emergency room or walk-in clinic for doctors who would try to get them into Fantus Clinic. The patients would eventually get their tests, but the results were never sent back to the community health centers."

The referral and linkage project has corrected that problem, said project co-director Martha Ferguson. Since the program began last fall, 325 patients have been referred from Cook County to Alivio or Bethel. At the same time, the community clinics have referred 230 patients to the hospital's subspecialty clinics, according to Ferguson. Just as encouraging is the speed with which appointments are being scheduled and kept, she added.

"Ninety-three percent of all patients referred from the centers to the subspecialty clinics were able to have an appointment set up within one working day of their request. And 81 percent of those who kept their referral appointments at Cook County had test results forwarded to the community health centers within one week," Ferguson said.

The project is funded by a grant from the Robert Wood Johnson Foundation

and local contributions to the Illinois Primary Health Care Association. Because of the program's success to date, two additional Chicago facilities will link with Cook County in July. The project is also developing an automated referral system, Dr. Ansell said.

"Overall, I've been very happy with the program," said Don Woznika, MD, one of the program's two participating physi-

cians. He has worked at Alivio for a year and a half. "We were always interested in forming some kind of relationship to help our indigent, uninsured patients. This gave us a formal channel that allowed our patients to be seen and [enabled] us to get feedback regarding specialty consultations. We seem to be developing better doctor-patient relationships."

"The patients get all the benefits of

primary care, and we have access to an improved subspecialty referral and response system so that we're not sending patients into some black hole," said Tim Fadar, MD, the program's other physician, who treats patients at Cook County and Bethel. "From an economic standpoint, many people who once fell between the cracks now can get medications and lab studies and subspecialty care at no charge from Cook County Hospital. Through this arrangement, I can be involved with Cook County and still be a primary care physician in a community center. The link between the two is ideal." ■

Blue Cross Blue Shield



REPORT

FOR *Illinois Physicians*

SCREENING MAMMOGRAPHY POOR COMPLIANCE WITH RECOMMENDED SCHEDULES

Screening mammography is a diagnostic intervention with established efficacy as a case finding methodology. Furthermore, studies have repeatedly demonstrated that screening mammography programs are associated with increased survival rates for breast cancer in women aged 50 or over, although some recent studies have questioned the ability of screening mammograms to improve breast cancer survival rates in women aged under 50. Although many women find mammography to be an uncomfortable and/or disquieting medical test, mammography is associated with essentially no morbidity or mortality. Consequently, it might be expected that compliance with screening mammography schedules, as set forth by the American Cancer Society and others, would be extremely high. Unfortunately, the experience of Blue Cross Blue Shield of Illinois (BCBSI) is quite contrary to this expectation.

In 1991, BCBSI performed a pilot study of the rate of screening mammography in approximately 27,000 women employed by 5 different employer groups covered by BCBSI. The study demonstrated that only 16% of women over age 50 had received at least one mammogram in the 2 year period of the study. This disturbingly low rate of mammography prompted BCBSI to draw public attention to the issue, and to repeat the study on a larger scale, this time predominantly studying the women employees of a large 5-state midwest employer. Utilizing a claims review methodology, the mammography rate for women age 49-59 was 33% in Illinois; the rates were not significantly different in the other four states. Although these rates were improved as compared to the initial study, the recent results are still disappointing, and have raised the issue as to what interventions might be undertaken to increase mammography utilization.

Currently, BCBSI has instituted a post-card reminder program, informing women of the desirability of periodic screening mammography and encouraging them to contact their primary care physicians in regard to having a screening mammogram. BCBSI is also undertaking a campaign, of which this "Blue Sheet" is a part, of informing physicians about low screening mammography rates so as to stimulate them to urge their women patients to obtain screening mammograms. Finally, BCBSI would welcome the suggestions of Illinois physicians as to what else BCBSI might do to increase compliance with recommended screening mammography schedules. Write to:

Arnold L. Widen, M.D.
Corporate Medical Director
Blue Cross Blue Shield of Illinois
233 N. Michigan Avenue, Suite 1525
Chicago, IL 60601-5655

Clinic wins rural health award

COMMUNITY COLLABORATION: Improved access results from cooperation between a southern Illinois hospital and the county health department. By Anna Chapman

[MOUNT CARMEL] Nearly two years ago, health care providers in Wabash County, in southeastern Illinois, decided they couldn't wait for the federal government to improve access in their community. Now Wabash General Hospital and the Wabash County Health Department have received the Illinois

Rural Health Association's Exemplary Project Award for their cooperative efforts in launching the Wabash General Hospital Volunteer Clinic.

"The uniqueness of the whole project caught the attention of the awards committee," said Barbara Dallas, committee chairman and an IRHA board member.

"We felt that such a unique and collaborative effort deserved recognition because of the need it is addressing."

The first joint effort between the hospital and the county health department, the clinic opened in September 1992. Since then, more than 1,400 of the 14,000 Wabash County residents have received care at the clinic, which is located at the hospital, said Wabash General chief executive officer Roger Holloway.

THE VOLUNTEER CLINIC was established at Wabash General to improve access to care and to alleviate inappropriate and expensive use of the hospital's emergency room, Holloway said. Wabash County is similar to other rural Illinois counties, with an economic base of farming and some industry and the problem of double-digit unemployment, he noted. There is some oil, but because of recent price fluctuations, that industry has yielded few jobs. The average annual income for the county is \$3,000, he said.

The clinic is open two nights a week, Holloway explained. One night it serves pediatric patients and the other, adults. Patients are assessed fees based on their ability to pay, but most pay no fee. The average cost for those who do pay is \$5, he said. Most important, the clinic is staffed entirely by volunteers.

Those volunteers include physicians, nurses, clerical staff recruited from the community and local junior college nursing students, Holloway said, noting that the hospital established a \$1-a-year contract with physicians and purchased

additional liability insurance for them. The clinic receives no outside funding other than small local donations.

The county health department schedules appointments, conducts screenings and makes referrals, said Michael Henry, Wabash County public health administrator. The health department also maintains a fund to pay for prescriptions for patients who are 19 and younger, Henry said.

Lawrence P. Jennings, MD, a Mount Carmel internist, likened his work at the clinic to practicing in the emergency room. "Sometimes we run across problems we don't normally see," he said, explaining that the lack of physicians in the area may make it difficult to refer to specialists. The clinic's physicians include three internists, one pediatrician, one family physician and one surgeon, he said.

The predominant role of the clinic has been providing short-term acute care, Dr. Jennings said. "This works very well," he noted, but added that preventive care must be the long-term goal. "It's easier to treat hypertension than a stroke."

"Physicians work very hard; there are a lot of long hours," Dr. Jennings continued. "When it comes your Tuesday night [at the clinic], you sometimes don't know how you're going to squeeze in the regular patients during the day. But you feel good."

"It's not utopia, but it's better than sporadic care," Holloway said. "And it's certainly more cost-effective." ■

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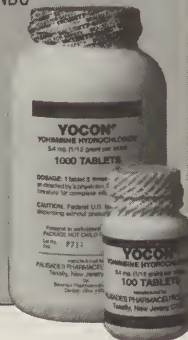
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Improving health in Will County

PROBLEM SOLVING: A new grant program is funding innovative approaches to address community needs. By Kathleen Furore

[JOLIET] Limited access to health care, especially for the poor. Teen pregnancies and a lack of prenatal care. Substance abuse and the spread of sexually transmitted diseases. A lack of knowledge about basic health care needs. Those problems are responsible for deteriorating health among area residents, according to the Will County Health Department's Community Health Planning Committee. And local health officials say that to some degree, those problems mirror the problems faced in every Illinois community.

But Will County health care advocates hope they can combat some of those health problems through the Social Accountability and Community Collaboration Grant Program established by Joliet's St. Joseph Medical Center in November 1993. The grants enable local organizations to secure funding for programs designed to remedy the underlying causes of health problems in the county, according to St. Joseph officials.

"We often fail to recognize the impact that problems like street and family violence, poor nutrition and inadequate access to health services have on the vitality of our community and the health of our population," said David W. Benfer, president of St. Joseph. "By making funds available, we hope other community groups and organizations will begin working together to identify opportunities for improving some of these problems."

Underscoring its commitment to the community it serves, St. Joseph earmarked \$500,000 for 1994 grants. According to hospital administrative fellow Kevin Carey, the center received 42 applications — totaling more than \$1.9 million in requests — from individuals and organizations describing programs they would implement if awarded grant money. To date, the center has awarded seven grants; four more are pending.

"We wanted the programs to focus on federally designated, medically underserved areas in the county or on health professional shortage areas," Carey said, explaining the criteria used to select grant recipients. "We also wanted them to address primary care health needs by focusing on the root causes of problems, to address specific gaps in health or social services for the disadvantaged and to demonstrate they would have long-term effects."

Grant recipients and their programs include the following:

- The Guardian Angel Home in Joliet, for a legal and medical advocacy and crisis intervention program for victims of sexual assault;
- The Will-Grundy Medical Clinic, for a dental clinic to treat the medically underserved;
- Joliet Township High Schools, for expansion of an existing program that encourages students to stay drug-free;
- The Joliet Police Department, for a new substance abuse program that requires at-risk youths to undergo substance abuse assessment and testing; and
- Lockport Township High School and Fairmont School District, for hiring a substance abuse counselor.

The Will-Grundy Medical Clinic is using the grant money to purchase sup-

plies and equipment and pay a coordinator, who will oversee the new dental center, said Theodore M. Kanellakes, MD, a Will-Grundy board member and head of its medical advisory committee.

"The St. Joseph grant means a lot," said Dr. Kanellakes, who was instrumental in establishing the free clinic. "There are a significant number of dental problems, as well as medical problems,

among the indigent, and this money allows us to offer additional care. Dental care impacts overall physical health; you can't divorce one area of the body from another. We're now a full-service clinic. We were taking things one step at a time, and the money from St. Joseph helped us take that extra step."

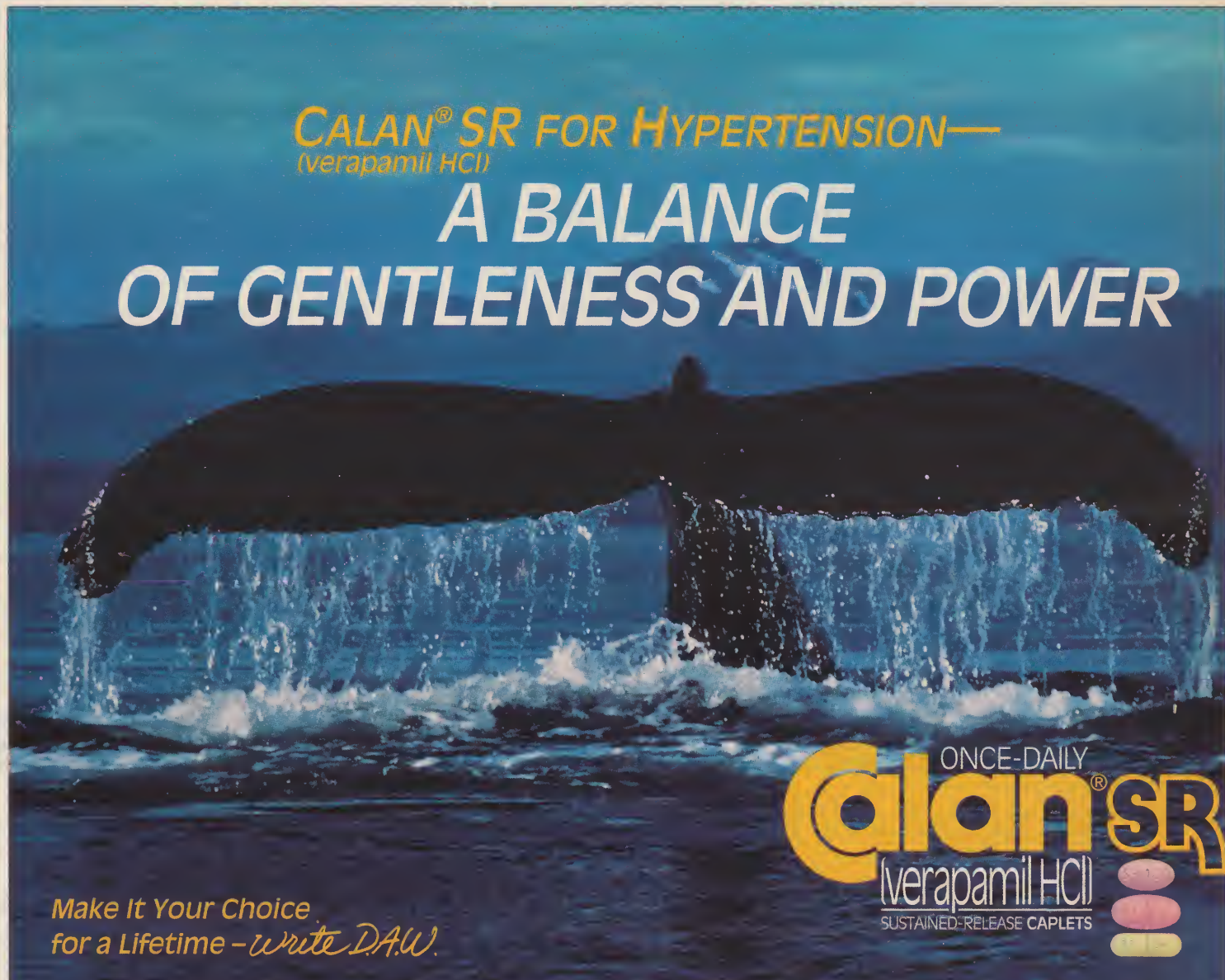
"This grant is what has been missing," said Sister Dorothy Kinsella, director of a

Guardian Angel Home program called Groundwork. She said the home can now work with local hospitals to ensure that advocates are available to counsel rape victims as soon as possible after an assault. In addition, staff will work with the state's attorney's office to make sure victims have legal support if they press charges.

The entire \$500,000 set aside for the grants has not yet been awarded, Carey said. "St. Joseph Medical Center wants to be a catalyst for changing lifestyles in Will County. Our goal is not necessarily to deplete the fund, but to grant money to worthy programs that will help the community by meeting the needs we've identified." ■

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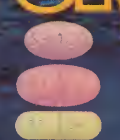


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Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.
Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving 1 V verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.
Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy, and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1° 2° 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

Cracking down on lighting up

Some anniversaries don't really warrant celebration – at least yet. Mid-January marked the 30th anniversary of the first federal report on the health effects of smoking. Commemorating that event this year, several medical groups and former surgeons general called on Congress and the administration to enact tougher anti-tobacco laws, as reported in the *New York Times*. In addition, a health care group – formed by the American Heart Association, the American Lung Association and the American Cancer Society – issued a report card on how the federal government has controlled tobacco use.

The grades were low. Congress, the White House and most federal agencies received D's and F's for their efforts during the last 30 years. The highest grades given were B's, received by the Environmental Protection Agency, which placed environmental tobacco smoke in the "worst pollutant" category, and the Veterans Affairs Department, which banned smoking in all its hospitals.

In response to the lack of federal efforts, the group called for the Federal Trade Commission to regulate tobacco advertising, Congress to raise cigarette taxes by \$2 a pack and the president to ban smoking in all federal buildings.

Today, the decrease in smoking rates for young people has stalled, according to the CDC, as reported in *JAMA*. The writers said that when comparing the

use of alcohol, cigarettes and other drugs, only cigarette use failed to decline substantially among high school seniors between 1981 and 1991. And during the past decade, smoking among white teens has hardly declined at all.

Aggressive cigarette advertising campaigns have resulted in a major increase in smoking by girls who are too young to legally buy cigarettes, according to a study published in *JAMA*. The researchers concluded that young people are encouraged to begin a lifelong addiction before they're old enough to fully recognize its long-term health risks.

Another study, also reported in *JAMA*, provided biochemical evidence that pregnant women exposed to passive smoke, as well as their fetuses, accumulated nicotine at measurable levels. The researchers said that this accumulation of cigarette smoke constituents reflects long-term systemic exposure to toxins and may well correlate with perinatal risks.

Every day, the evidence mounts that direct and indirect tobacco smoke creates a serious health risk for everyone. Although the Illinois General Assembly has passed some anti-tobacco legislation, there's more work to be done. Let's renew our commitment to counsel our patients about smoking and to support anti-tobacco bills in the upcoming legislative session. Maybe the next 30 years will bring results that are really worth celebrating.

PRESIDENT'S LETTER

We agree on reform

By Arthur R. Traugott, MD



Any system that raises significant barriers between patients and physicians will not provide the quality care our nation expects and deserves.

Organized medicine is still working hard at shaping health reform legislation that will support high-quality care. In early March, the AMA sponsored meetings with some members of Congress and policy-makers in Washington. I was part of a nationwide group of grass-roots physicians who talked to legislators about reform and demonstrated medicine's unity on the issue.

Medicine is sometimes negatively portrayed as a special-interest group. Medicine has always had a special interest – our patients and the need to provide them with quality medical care. It's our professional obligation to make sure that nothing impinges on the physician-patient relationship or jeopardizes patient care.

Prior to the meetings, the AMA also wrote a letter to U.S. senators and representatives about the elements that must be included in any health system reform legislation. That letter was signed by 64 medical and specialty societies – including ISMS – and published in the Feb. 23 issue of the *Wall Street Journal*. The letter states:

As physician organizations, we agree on the need for health system reform legislation that gives every American universal coverage for health care and effectively controls rising health costs, while ensuring quality patient care. These principles have been articulated by numerous medical organizations in their various health system reform policies and proposals. They remain the foundation of our legislative agenda, which is to enact laws that assure universal coverage for a standard set of health benefits, regardless of employment or economic status.

We believe that any measure adopted by the Congress should:

- Achieve universal coverage through a program where responsibility is shared by employers, individuals and government in paying for health care coverage.
- Assure that every American has his/her choice of health plans, physicians and other providers.

- Establish competition in the marketplace as a method of slowing the rate of growth in health spending.
- Give patients price and quality information to permit them to make informed decisions.
- Eliminate needless bureaucracy to create an efficient, streamlined and coordinated system that minimizes red tape for patients, physicians and other providers. Health system reform must leave medical decision making in the hands of physicians and their patients.

We believe that to enable physicians to best serve the interests of their patients, meaningful health system reform also must contain these elements:

- Significant antitrust relief that enables physicians to have a strong voice to balance the growing corporate and government domination of health care.
- Allowance for physician-directed health care networks.
- Enhanced self-regulatory powers that would enable the profession to effectively police itself and its members without the threat of unwarranted litigation.

We also believe that major reforms in the professional liability system must be enacted, including a \$250,000 cap on noneconomic damages, limits on plaintiff attorneys' fees and other measures that would minimize defensive medicine.

Every American will be affected by this legislation. The focus of policy-makers should be on how their decisions will affect patient care. Any system that raises significant barriers between patients and physicians will not provide the quality care our nation expects and deserves. We believe the above principles outline a framework for establishing constructive, effective and needed health system reform.

This letter and our trip to Washington are our most recent contributions to the unified efforts of organized medicine. Only if we remain united can we have a significant impact on reform.



"I tried to figure out your bookkeeping.
Now I'm being treated for depression."

GUEST EDITORIAL

Drive-through deliveries

By Suzanne Gordon

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Nine years ago, in what many women may come to regard as the golden era of labor and delivery, I had my first child. I was 38 years old, the only child of a widowed 75-year-old mother who had long ago forgotten how to diaper a baby, a career woman whose friends were in the work force and whose husband couldn't take time off from work. I endured 30 hours of back labor, three and a half hours of pushing and an episiotomy before my baby appeared. I had a normal vaginal delivery. Even so, I needed every minute, every second, of my four-day hospital stay.

Now, it seems I am a relic, a dinosaur. In this new era of health care reform, many managed care plans have turned labor and delivery units into the equivalent of drive-through banks.

In California, most HMOs allot women who have normal vaginal deliveries only 12 to 24 hours in the hospital after giving birth. In Massachusetts, one of the nation's leading health maintenance organizations, the Harvard Community Health Plan, announced last fall that it was turning its voluntary policy of allowing women to stay in the hospital for 24 hours, followed by 16 hours of assistance from a home health aide, into a mandatory one. Only now, the plan has eliminated the home health aide.

We know what this all means to insurance companies: higher profits. But what does it mean to women?

For some women, perhaps these policies are just fine. But for women who have deliveries like mine, they're cruel and unusual.

When my baby was born, I wasn't just exhausted, I hurt like hell. I received shots of pain medication four times a day and suffered the usual side effect, constipation. For the first 30 hours or so – with an ice pack glued to my bottom and a catheter dangling between my legs – I was far more worried about going to the bathroom than bonding with my baby. How, I wonder, could the nurses who

managed my pain have helped me if I had been at home?

When I was finally able to move on to the work of bonding, again it was the 24-hour-a-day contact with the nurses that made the difference. I depended on these experts to teach me the art of mothering. I remember peering awe-struck through the nursery window as the nurses gathered a howling newborn in one hand while rocking a calm baby in the other. Watching them bathe my child and swaddle her made me realize that these were skills that I could actually learn.

The power of what these nurses taught me lay not only in the information they conveyed but also in the human relationship they established with me and between me and my baby. No piece of paper cataloging facts about child care, no instructional video I could watch at home – the prescription now replacing contact with RNs in many hospitals – could possibly have substituted for those living encounters.

Throughout history, women weakened by childbirth have benefited from such personal care-giving. In the past, midwives and their helpers delivered care in the home during and after the birth. Eventually, the hospital has come to substitute for that kind of care.

Yet now this relationship is being removed from regular health care. Moreover, this may not be the end of that process. One experienced nurse at a major Boston teaching hospital told me she has heard talk of "refusing to allow women to come into the hospital unless they are sufficiently dilated."

Hillary Rodham Clinton insists that the administration's health care plan will be good for women and children. Yet this preview of the effects of cost controls should alert all women – and all women's health advocates – to the dangers of a plan that manages the "care" right out of health care. To deny women and children the time they need in the hospital and the assistance they need at home is to make a mockery of the very ideal of health care reform.

GUEST EDITORIAL

What were Clinton's real goals for reform?

By Steve Daly

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There were all those presidential trips to the clinics in Rochester, N.Y., the nursing homes in Georgia and the long-term care programs in Minnesota.

There was a speech to Congress viewed by many as President Clinton's finest moment in the White House, the moment when he drew a line on universal health insurance coverage and, for once, sounded like he meant it.

From Hillary Rodham Clinton, the high priestess of health care reform, there were the attacks on the rapacious health insurance industry and the tear-in-the-throat speeches to various interest groups.

And there were her knock-'em-in-the-aisles appearances before a host of congressional committees, appearances in which the first lady smote the Republican dragons and comforted edgy Democrats with her expertise.

There were, the Clintons tell us, acres of letters to be read and hundreds of conversations with "real Americans" and the promise of a fight to the finish with the defenders of the indefensible status quo.

Now, everything's negotiable. Basically, the plan designed by Mrs. Clinton, her long-running "task force" and health care guru Ira Magaziner is as dead as Madison Guaranty, that controversial savings and loan in Arkansas.

Diminishing public support, driven by wildly dishonest but brutally effective TV commercials sponsored by your friendly insurance companies, has choked the air out of the sweeping, complex plan.

Two polls out last week showed public support for the Clinton plan on the wane, with 51 percent of those asked by an ABC News/Washington Post survey saying that "the more they heard about the plan, the less they liked it."

Right now, for all the administration's bluster about fighting "an air war and a ground war" to protect the plan, health care reform is in the manipulative hands of the congressional committees.

Having lost the public relations war, the administration and its defenders insist that the trip through the congressional maw is just business as usual, the way things work in Washington.

The fact is, Bill and Hillary Clinton are no longer major players in the health care debate. The president cried "foul" last week, complaining, "I don't have as much money to run television ads as the health insurance industry does."

What he does have is the highly touted bully pulpit of the White House, a vehicle Clinton has failed to use effectively in defending his ideas.

Meanwhile, lawmakers who pose as Clinton allies, such as Sen. John Breaux (D-La.), call for a bipartisan return to the drawing board nearly 18 months after the health care debate began.

For all Clinton's skills as a communicator, and for all the time and effort expended by Mrs. Clinton, it's hard to

fathom what their long-range intentions were for health care.

Were they ever entirely serious about "managed competition," "regional health alliances" and employer mandates to pay for coverage?

Or was the presidential intent to establish the terms of the debate, then take credit for whatever emerged at the end of the legislative process? Was policy wonk Magaziner the key

adviser on this strategy, or was political consultant James Carville waving the baton?

If Clinton was serious, how did he fall into the trap of courting groups such as the Business Roundtable, the U.S. Chamber of Commerce and the National Association of Manufacturers?

At one moment, Clinton would rail against the medical and insurance lobbies, telling crowds on his health care promotion tours that the diminution of the administration's plan would mean the triumph of the special interests.

In the next moment, Clinton the conciliator would emerge, wooing the business community and buying into the suggestion they might line up with Bill and Hillary and the "New Democrats."

In the end, of course, the business community – rarely an agent of fundamental social change in America, in case you hadn't noticed – walked away from Clinton's blandishments.

Soon after the corporate courtship, the Congressional Budget Office offered a gloomy assessment of the Clinton program's cost and its tax implications.

The suspicion here is that Clinton always intended to take what the process gave him and claim victory. By 1996, we'll know if that was enough.

Having lost the public relations war, the administration and its defenders insist that the trip through the congressional maw is just business as usual, the way things work in Washington.

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ISMIE Update

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Act offers protection for 'Good Samaritan' physicians

A 1993 Illinois case used the doctrine to aid a physician's defense. By Kathleen Furore

There are some situations physicians hope they'll never encounter: witnessing a car accident involving serious injuries, seeing a pedestrian collapse on the sidewalk, delivering the baby of a patient they've never seen.

Although instinct usually tells physicians to step in and help when emergency strikes, the pressure to practice defensive medicine may cause them to wonder, Will I be liable if a bad outcome occurs?

If a lawsuit is filed seeking

damages for injuries allegedly suffered as a result of "Good Samaritan" actions, physicians have legal recourse thanks to an Illinois doctrine originally enacted in 1923.

According to William J. Rogers, a partner in the Chicago law firm of Bollinger, Ruberry & Garvey, the Good Samaritan Act in theory protects physicians if the following conditions are met: The physician must not have prior notice of the illness or injury, must provide emergency care, must not charge a

fee for the services and must treat the victim in good faith and without gross negligence. However, the act has rarely been used as a defense, because actions that meet all the requirements arise so infrequently, Rogers said.

"There aren't many cases dealing with the Good Samaritan Act, because there are only rare circumstances when it would ever come up — an auto accident, a building collapse or an emergency room, delivery room or resuscitation setting

where you just grab someone to help," Rogers added. "Typically, most incidents occur when there already has been some type of physician-patient contact or when the doctors are being compensated."

A CASE DECIDED by the First District Appellate Court of Illinois in December 1993, however, did rely on the doctrine to aid in a physician's defense. *Villamil vs. Benages* is important because it "discusses the issues out there and is one of the few cases that deals with the Good Samaritan Act," Rogers said.

According to the *Westlaw* legal citation, the patient had experienced premature labor and sought help in a hospital at which her regular physician did not practice. After delivering a premature infant who eventually died, she and her husband filed a malpractice complaint against the hospital and the physician who was present at delivery. Later, they filed a complaint against the physician, seeking damages for the infliction of severe emotional and mental distress. The plaintiffs claimed that the physician was away from the table at the time of delivery and that the baby fell; the physician said he delivered the baby and handed the infant to the nurse.

After the trial court dismissed counts of emotional distress — a decision that was upheld by the appellate court — and entered an order granting the physician a motion for summary judgment on all counts, the plaintiffs filed a notice of appeal. One of the

issues presented for review was whether the trial court erred in granting summary judgment in favor of the physician on the basis of the Good Samaritan Act.

The trial court found no material issue of fact that precluded the entry of summary judgment based on the Good Samaritan Act, and the appellate court subsequently ruled that the trial court had properly granted summary judgment in favor of the defendant based on the doctrine. The appellate court cited the fact that the physician had no prior notice of the patient's illness or injury, that he had provided emergency care and that he did not send a bill or collect money for services rendered.

Because the Good Samaritan Act has been infrequently tested, it is difficult to predict how much protection it provides physicians — even though it has been amended a number of times since 1923, according to Rogers. It originally confined protection to physicians who administered care to motor vehicle accident victims and was later changed to include victims "of an accident at the scene of the accident or in case of nuclear attack," he said. In 1973, the doctrine was further amended by substituting the word "person" for "victim of an accident at the scene of the accident or in case of nuclear attack" and by adding that physicians must not have prior notice of the illness or injury, Rogers added. He also noted that as a result of the 1988 case *Johnson vs. Matviuw*, the act now applies

(Continued on page 9)

MALPRACTICE ROUNDUP

Defense's access to information restricted

An Illinois appeals court ruled that a hospital's malpractice attorney couldn't interview the hospital employee whose conduct was the basis for a claim against the hospital. Because the ruling in *Almgren vs. Rush-Presbyterian-St. Luke's Medical Center* was based on physician-patient privilege, the case has potential implications nationwide.

The plaintiff claimed the hospital was responsible for injuries she suffered when she was hit by a train while she was out of the hospital on a day pass issued by a resident physician. At the time of the accident, the plaintiff was a psychiatric inpatient at the medical center.

Although the trial court granted the defendant's request for an ex parte interview with the resident, the appellate court ruled the plaintiff had the right to prevent the resident's disclosure of privileged information except through formal discovery and in the presence of the plaintiff's counsel or the court.

The ruling in *Almgren* relied heavily on *Petrillo vs. Syntex Laboratories*, which prohibited a defendant's attorneys from engaging in ex parte discussions with subsequent treating physicians. But this case went beyond *Petrillo*, because it precluded a hospital from preparing its own employees for deposition and from developing a defense strategy before the start of formal discovery. ■

Pretrial settlement agreements barred in Texas

Texas became one of only four states in the nation to bar "Mary Carter" agreements — settlement agreements, often reached just before trial, between plaintiffs and several defendants in a multiple-defendant lawsuit. In these cases, settling defendants are encouraged to help convince the court of the remaining defendant's culpability in exchange for a partial refund of their settlement money if the award to the plaintiff exceeds a predetermined amount. In establishing the ruling, the court in *Smith vs. Elbaor* noted that such agreements foster litigation against the remaining defendant.

The case involved a plaintiff who had been injured in an auto accident, treated at one hospital and eventually transferred to the care of the defendant physician, Dr. Elbaor. The plaintiff's injury took what was referred to as a "stormy course," and a lawsuit was filed against the hospital and three of the plaintiff's treating physicians. On the day of the trial, a Mary Carter agreement was reached between the plaintiff's attorney, the hospital and the two other physicians.

A trial court ruled in favor of the plaintiff. State supreme court judges, however, determined that no amount of instruction to a trial jury could undo the bias that occurs when a defendant argues about the liability of a co-defendant. ■

Return your ISMIE UPU

Physicians who have received Underwriting Profile Update surveys to complete and sign should return them to ISMIE as soon as possible. Some policyholders who have not yet returned the forms may have received notice that their policies have been placed in nonrenewed status for the period beginning July 1. These physicians must return their forms immediately to be reinstated for the next billing period.

Underwriting Profile Updates are mailed to policyholders about every two years. They enable policyholders to report changes to ISMIE and ensure that physicians have appropriate coverage and that ISMIE records reflect their current practice. Updates also provide ISMIE underwriters with current background information, such as addresses and telephone numbers, as well as up-to-date physician signatures. Policyholders who have questions about the forms are encouraged to contact the ISMIE underwriting division at (312) 782-2749 or (800) 782-4767. ■

ISMIE presents seminars on risk management, litigation process

Two ISMIE-sponsored seminars – one designed for physicians involved in malpractice litigation and their spouses and the other for medical office staff – are scheduled from April to November at various locations throughout the state.

"Taking Control: Managing Your Malpractice Lawsuit" offers information about ISMIE's claims management procedures, the legal process and coping mechanisms to deal with the emotional turmoil of malpractice litigation. After completing the two-hour seminar, participants understand the role of their ISMIE claims analyst, the steps in the litigation process, common legal terminology, ways to act as their own advocates and the effect of stress on their professional and personal relationships.

The seminar is scheduled for April 6 at the Holiday Inn City Centre in Peoria,

Sept. 28 at the Hyatt O'Hare in Rosemont, Oct. 19 at the Collinsville Holiday Inn in Collinsville and Nov. 2 at the Oak Brook Hyatt in Oak Brook. The program is held from 6:30 p.m. to 9 p.m. and includes refreshments. It is free to ISMIE-insured physicians and their spouses. Participants will receive two hours of Category I CME credit for the Physician's Recognition Award of the AMA.

The nonclinical tasks performed by

medical office staff are often cited as contributing factors in malpractice lawsuits. To help fight that trend, ISMIE has developed the seminar "Risk Management: An Essential Office Practice." The program teaches office personnel the importance of implementing risk management procedures.

Nurses, receptionists, office and business managers, and other medical office personnel can benefit from this two-hour program. Among the topics to be covered are risk management objectives, reasons patients sue, the importance of patient communication, the general principles of medical record documentation, medical record access and retention, office proce-

dures for documenting phone calls, proper methods for patient follow-up and the management of noncompliant patients. Physicians are invited to attend the seminar with their staff members.

The seminar is scheduled 44 times between April 6 and Nov. 16. Morning sessions begin at 8:30 a.m. with a continental breakfast; afternoon sessions begin at 1 p.m. with refreshments. Participants must register in advance by mail. The cost of the seminar is \$10 per registrant.

For more information about ISMIE's educational seminars or to request registration forms, call (312) 782-2749 or (800) 782-4767. ■

Good Samaritan

(Continued from page 8)

to doctors who render emergency care in a hospital setting.

There are no guarantees, however, that the doctrine will protect physicians in every emergency situation. An article published in the February 1994 issue of *Medical Liability Advisory Service* warns, "There are some significant pitfalls that must be realized before all of one's eggs are put into this basket."

According to the article, those pitfalls include the fact that this doctrine, which exists in some form in each state, is a defense only for use at trial and does not affect the early stage of pleading, during which a case may be dismissed. In addition, the threshold for a court's finding of "gross negligence" is much lower for physicians than for lay people; an attorney might assert that physicians have an unwritten duty to respond to every emergency in the hospital unless such situations are specifically excluded from their contracts; and juries may not accept physicians as Good Samaritans, since some people assume physicians have a duty toward everyone.

JUST WHAT DOES the Good Samaritan Act mean to practicing physicians? Wesley H. Gregor, MD, an internist at Chicago's Northwestern Memorial Hospital, has been a Good Samaritan at the scene of a golf cart mishap and two automobile accidents. "When I was in med school, someone asked what I would do if I was on a bus with my black bag and white tunic and somebody needed help," Dr. Gregor said. "I joked that I'd probably pull the cord and get off at the next stop. Of course, I wasn't equipped [to handle that kind of situation] then, and the desire to help if no one else was there would overrule now. Your basic instinct as a physician is to help, and most would. But there are all sorts of litigious people out there. The Good Samaritan Act makes us more comfortable."

That attitude was echoed by Sharon T. Flint, MD, an Oak Park pediatrician. "Most physicians have a built-in need to get involved; it's a reflex response. You don't even think about the law until after the fact, when you start thinking about what you've done." ■

"Shhhh! Don't Tell Anyone..."



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SIBERIAN ADVENTURE

Cardiac care on the tundra's *edge*

A teaching trip to Russia allows a clinical team to practice the old-fashioned way – but with modern techniques.

BY ANNA CHAPMAN

We had the opportunity to teach some people who wanted to learn so badly. It was medicine of 34 years ago, when there were no phones, no pagers, no paperwork, no lawyers, no insurance companies. All I did was see patients and teach," said Vincent J. Bufalino, MD, medical director of the Edward Cardiovascular Institute on the campus of Edward Hospital in Naperville.

Those were Dr. Bufalino's impressions of a 10-day mission to take American-style cardiac care to Krasnoyarsk – a city of 1 million people on the southern edge of Siberia. He recounted his story Feb. 16 during a presentation to the Edward Hospital Mended Hearts Chapter, an area support group for heart disease patients and their families.

In October 1993, an 11-member clinical team that included Dr. Bufalino and Zev Davis, MD, director of cardiac surgery at Edward, journeyed to Siberia to set up the first cardiac catheterization laboratory in the region. The goal of the mission was to teach Russian cardiologists about current cardiovascular diagnostic and therapeutic techniques such as percutaneous transluminal angioplasty, bypass surgery, directional coronary atherectomy and transesophageal echocardiogram.

Dr. Bufalino said he learned about Krasnoyarsk from a guest lecturer from the city who told some interesting stories about medical care there. For instance, the cardiologist described the process by which surgeons back home would chip ice from the local river and place it on patients to lower their body temperatures to 68 degrees Fahrenheit before they performed valve replacement surgery. "They would wait 30 to

40 minutes, kind of rip [the patients] open, and get in there, put the valve in and get out. It's something we haven't used in this country for about 30 or 40 years, and we sure hadn't been chipping ice out of the river," Dr. Bufalino said.

The Russian cardiologist subsequently invited the Edward physicians to Krasnoyarsk to help local doctors learn U.S. techniques.

News coverage of Moscow in the fall of 1993 caused some apprehension among the Edward team members, whose trip was only a month away. "In September, there had been all those tanks in Moscow and buildings being bombed," Dr. Bufalino said. "That clearly shook the team. The bloody bodies on CNN were not what my nurses needed to see." In mid-September, conservative rebels overtook the Russian Parliament. After they were defeated by Russian President Boris Yeltsin, martial law and a curfew were instated. However, the day the team arrived, Oct. 16, martial law was lifted in Moscow, Dr. Bufalino noted.

First, the team members began acclimation to the 12-hour time difference, Dr. Bufalino explained. The next day, during their first tour of the hospital, the team discovered that the only equipment in what was to become the intensive care unit was a monitor that looked like it had been manufactured in the 1960s. When team members walked into the operating room, flies were entering an open window.

The team was also somewhat unprepared for the differences between the two countries' perception of science, Dr. Bufalino said. "They put a man on the moon; we put a man on the moon. They have fancy planes; we have fancy planes. So we thought that the science part would be similar and the technol-



Dr. Bufalino

Terry Vitacco

SIBERIAN ADVENTURE



Hospital waste is burned in large holes outside the facility's main building. Surrounding the site are abandoned construction projects.



The Edward Hospital team teaches its Russian counterparts how to perform modern cardiac surgical techniques.

ogy would be the same. It was anything but that. We were flabbergasted by the total lack of equipment, the total lack of anything. It's not that they don't have the same abilities. It was just not important [to them]. What was important [under the Soviet regime] was being a superpower. It was an interesting revelation."

The team was told the hospital had 700 cardiac patients. "I thought it was baloney, but it was the truth," noted Dr. Bufalino. "People come to this hospital from 150 to 200 miles away. Not only had there not been bypass surgery in this region, but no one living 2,000 miles away in any direction had even had an angiogram."

The Edward physicians also spent a great deal of time examining patients – a task that required the use of a translator, Dr. Bufalino said. "There would be 12 to 15 cardiologists in the room, and we would bring the patients in one at a time with a translator. We would get the history, examine the patient and make a diagnosis. We would make a plan, and then we would

move on. We would do as many as we could do until nobody could take it any more. The translator fainted one day, we had done so much. That part was just phenomenal.

"We saw tons and tons of heart disease," he continued, noting that every patient had advanced disease. Many patients had experienced second and third heart attacks, and many were between 35 and 45 years old, he said. "They were people who were incapacitated, taking all the medicines they had."

The 1,000-bed hospital in Krasnoyarsk was five years old, "but it was like 1955 Cook County [Hospital] vintage," Dr. Bufalino said. "It was actually a lot of fun to take something that was very raw and turn it into our own environment in 24 hours. We started Friday morning at 9 a.m., and by Saturday morning, we were doing cath. That was fun."

But on the third day, the cath lab went down because of a blown fuse. The situation was rectified, though, by a Russian engineer who used a gum wrapper to substitute for the fuse, Dr. Bufalino said.

FORTY PEOPLE WATCHED the first angiograms the team performed, but there were problems, including a sideways image on the monitor and a broken dye injector, he said. A fully functioning injector was vital to determining which patients needed surgery, Dr. Bufalino explained. "So now we had no way to inject dye. They had an injector that they used for angiograms of the legs. It was an antiquated-looking piece of equipment with all metal parts that they had supposedly sterilized.

"We couldn't get our machine fixed," he continued. "The guy was on the table having skipped beats and chest pains. I got the catheter inside his heart, and we waited for the [injector]. We hooked it up with their connectors, and I said, 'Hit it. Let's go.'"

The team shot the dye through the injector, and it worked well, Dr. Bufalino said, adding that the procedure yielded "great pictures." As they continued performing the catheterizations, the physicians improvised on each case to adapt to the limitations of the equipment, he noted.

"At the end of that first morning, the nurse said, 'You know, we have not done one yet like we do at home.' We did things that we wouldn't have done at home, but we did them because we had no choice."

Dr. Bufalino said he was amazed to see that after surgery Russian physicians washed their hands while wearing their gloves. "They reuse everything. They saved everything we used – every catheter, every scrub brush, every needle, everything."

DURING THE FIRST BYPASS SURGERY performed by the U.S. surgeons, about 40 observers crowded into the operating room, and others watched from a turret above, Dr. Bufalino said. "It was like a grandstand. People were standing on top of stairs and on chairs. People were coming in [wearing] street clothes." Those individuals were turned away, he noted. "This was a big deal for this town. These folks were so excited. We were on the news in Moscow."

The U.S. team was impressed with the Russian physicians and their ability to learn the techniques quickly, Dr. Bufalino said, noting that by the last day, two of the cardiologists were performing angiograms unassisted. "They did them perfectly, neither of them ever having done one in their lives. In nine days, we got them to that level. We were proud, and they were proud." ■

Photos courtesy of Dr. Bufalino

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Student debate

(Continued from page 1)

Son's opponent, Lincoln Park senior Kevin Kabumoto, called nationalization of health care "more or less anti-American," but also noted that tax increases would be necessary to fund reform.

Adopting a single-payer system would be a "dangerous move," said Kenwood Academy senior Ruquaiyah Morris. Instead, a managed competition plan would prove cost-effective for the Illinois Medicaid system, she noted.

"It's time for Illinois to choose a single-payer system, not managed care," said Christopher Kaegi, a Kenwood senior. "A managed competition plan flushes millions down the bureaucratic toilet."

No reform plan would be adequate without a separate plan for Medicaid patients, said Ann Marie Scheffel, a junior from Curie. Claiming that it is unethical for patients to demand equal benefits without equal financial responsibility, Scheffel called for an overhaul of the welfare system. "If you reduce the number of impoverished people, you reduce the need for government assistance."

On the issue of access, Nancy Salas, a senior from Curie, said public aid patients should be allowed the same health care choices as other citizens. "Everyone, regardless of financial status, can be included in Clinton's new health care plan," she said, adding that preventive health measures are needed to lower the rate of disease.

"The Clinton plan does not help the poor because initially they will be kept

on Medicaid, which will be severely cut under the new plan," said Lane Tech senior Joseph Zefran. "What is needed is a system that will support everyone — rich, poor and middle class." Zefran recommended adopting a system similar to Social Security, which would be better-funded and guarantee quality care.

"There is a great need for responsibility to be written into any health care plan," said Rochanda Knox, a Lane Tech senior. She cited abuses of the Medicaid system by patients seeking prescriptions from numerous physicians and also called for greater government and physician responsibility.

FOLLOWING THE STUDENT DEBATE was a panel discussion, which included Clinton administration representative Chester Stroyne, a regional administrator for the U.S. Health Care Financing Administration; U.S. Rep. Dan Rostenkowski (D-Chicago) and Chicago Health Commissioner Sister Sheila Lyne. "This administration is willing to bite the bullet and give us some leadership," Rostenkowski said, suggesting that cost containment could be reached through voluntary efforts. He said the nation would need a "national revenue-raising base," but should not "put businesses out of business."

Lyne said she applauds President Clinton for his efforts but is concerned that his plan "may be very hard to access."

Stroyne noted that the key aspect of the Clinton plan is that it bans pre-existing condition clauses. He also praised states for moving ahead on reform. ■

Election

(Continued from page 1)

Riverside) will face Democrat Nancy Drew Sheehan in the treasurer's race.

Several hotly contested congressional races were also decided March 15. In a race that attracted national attention, House Ways and Means Committee chairman and 5th district incumbent Dan Rostenkowski received 50 percent of the vote to beat state Sen. John Cullerton (D-Chicago) and former Ald. Dick Simpson. Other election night congressional winners of note to physicians are U.S. 8th district Rep. Philip Crane (R-Wauconda), who survived a stiff challenge from state Sen. Peter Fitzgerald (R-Palatine) and Gary Skoien; U.S. 2nd district Rep. Mel Reynolds (D-Chicago), who defeated state Sen. William Shaw (D-Chicago) and Chicago Ald. Allan

Streeter; and U.S. 10th district Rep. John Porter (R-Deerfield), who beat conservative challenger Kathleen Sullivan.

Two additional races featured contests for open congressional seats. In the 11th district contest, state Rep. Jerry Weller (R-Morris) will square off against state Rep. Frank Giglio (D-Calumet City) to replace U.S. Rep. George Sangmeister (D-Joliet), who is not seeking re-election. Vying for House Minority Leader Robert Michel's 18th district post will be GOP candidate Ray LaHood and Democrat Douglas Stephens. Michel is retiring.

Some primary results were still unavailable as *Illinois Medicine* went to press. Watch the April 8 issue for in-depth coverage of the Statehouse races and other contests of interest to Illinois physicians. ■

Women's health

(Continued from page 1)

sented testimony detailing the medical community's response to violence against women. "Domestic violence is the single largest cause of injury to women in the United States — more common than automobile accidents, muggings and rapes combined. Every five years, as many women die from these injuries as all the Americans killed in the Vietnam War. The first place a woman turns is to her physician or to a local hospital emergency room."

In 1992, more than 130,000 children and between 200,000 and 300,000 women in Illinois were beaten, abused or killed in their own homes, Dr. Olson continued. "Doctors can and should be key players in violence prevention," she said, citing the AMA's domestic violence awareness initiative and the CMS Committee on Violence Prevention. "We need to build a comprehensive program of legislation and education of both patients and physicians designed to shed new light on the root causes of violence and take the steps necessary to break the cycle."

After the 1904 arrest of a New York woman for smoking in public, the right to smoke became a symbol for women's liberation and equality, said Barbara Silvestri, director of tobacco programs and policy for the American Lung Association of Metropolitan Chicago. The benefits of this perceived equality were short-lived, however, when it was discovered that "women who smoke like men die like men," she added.

In addition to suffering the same effects of smoking as do men — lung can-

cer, emphysema and heart disease — women smokers are also at increased risk for cardiovascular disease, cervical cancer and osteoporosis, Silvestri said.

In 1985, lung cancer was the leading cause of cancer deaths among women, Silvestri continued. Women typically start smoking when they are young, for various reasons, including low self-esteem, a desire to control their weight, pressure from family and friends, manipulation by tobacco advertisers and easy access to tobacco. Tobacco advertising often promotes themes of independence and physical perfection, she said.

According to Holly Howe, MD, an IDPH chronic disease epidemiologist, the incidence of breast cancer in Illinois is increasing. The state's breast cancer rate is nearly 8 percent higher than the national rate, she said. To detect these cancers early and achieve national public health objectives for the year 2000, "mammography screening must increase in Illinois."

Women who care for family members can suffer health problems such as back strain or stress, said Ruth Friedman, director of RespiteCARE and the Coalition on Family Caregiving. "Often there is a serious problem in terms of emotional health of caregivers. Many women are caring for children and parents at the same time."

To alleviate some of these problems, Friedman recommended respite services and supportive technology to minimize physical strain and allow caregivers a break from watching young children or elderly relatives. ■

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Carla Sommerfeld

MICHELLE PLOTKE, ISMS human resources assistant, received the Society's January-February Employee Recognition Award. Plotke is a service-oriented employee who was honored for her ability to provide ISMS and ISMIS employees with timely and pertinent information about their benefits and changes in the retirement plan.

Governor

(Continued from page 1)

ed States Congress to tame this budget basher," Edgar said. "We're not talking about less health care for the poor. We're talking about more effective health care — care that puts a premium on prevention, care that emphasizes regular contact with physicians, so colds can be treated in doctors' offices before they turn into pneumonia, which requires far more expensive treatment in hospitals."

The governor's proposal, slated to go into effect April 1, 1995, expands Medicaid managed-care choices, while retaining fee-for-service options. Medicaid patients will be able to choose to receive their care through one of four health care delivery alternatives: an HMO; an integrated network offering primary, secondary and tertiary care; a coordinated system in which patients choose a primary care physician who delivers care on a fee-for-service basis; and a traditional private insurance system in which the state pays the premiums and helps patients meet deductibles and copayments. In addition, Edgar's plan provides for the state to examine setting up

and making certain the system encourages that," Dr. Traugott continued. "Toward that end, there needs to be appropriate, medically based quality review."

Dr. Traugott noted, however, that the test of Edgar's plan may be whether an effective medical care delivery system can be ensured without inappropriate intrusion or micromanagement by government bureaucracy.

OTHER HEALTH-RELATED highlights of Edgar's budget proposal include funding for reforms in the Illinois Department of Mental Health and Developmental Disabilities. "Under this budget, staff-to-res-

ident ratios at our state mental health and developmental centers will reach their highest level in a decade," he said.

Among Edgar's proposed appropriations for the department are \$2.2 million to expand community programs, \$14 million to provide life-enhancing services to developmentally disabled individuals who choose to remain in nursing homes and \$1.2 million to move 50 people who have a mental illness and a developmental disability. The latter group will be relocated from state facilities to appropriate community settings.

Edgar said the \$231.1-million appropriation he slated for the Illinois Department of Alcoholism and Substance

Abuse will bolster prevention efforts and increase funding for treatment of high-risk alcohol and drug users.

"We must focus our attention on treating the victims of substance abuse and educating our young people about the dangers of addiction," Edgar said. The \$21.3 million earmarked for prevention reflects a \$3-million increase in general revenue spending over fiscal 1994, according to the governor's office.

Edgar also called for a \$6-million funding increase for the Illinois Department on Aging's home care program for needy senior citizens and a nearly \$1-million increase for programs to combat elder abuse. ■

We're not talking about less health care for the poor. We're talking about more effective health care — care that puts a premium on prevention.

a managed care system for long-term care patients who need physician and hospital services, according to the Illinois Department of Public Aid.

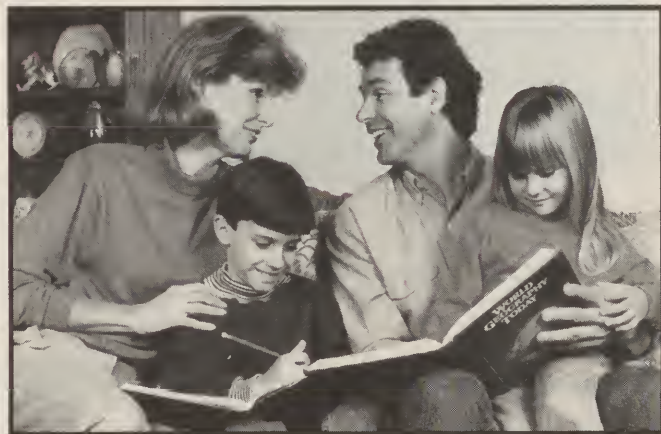
The plan requires approval from the General Assembly and the U.S. Department of Health and Human Services.

An integral part of Edgar's Medicaid reform plan is the elimination of the Medicaid health facilities assessment program, scheduled to sunset on June 30, 1995. The program, which does not directly affect physician reimbursement, would not be necessary under the governor's plan, since the state would pay capitated and negotiated rates to the managed-care entities and insurers covering Medicaid recipients. The state would not pay hospitals directly for the care they deliver to Medicaid patients, according to IDPA.

Edgar also called for a change in state law that would require more prompt reimbursement of providers and proposed eliminating the backlog of Medicaid bills by refinancing the state's debt at lower interest rates.

Responding to the governor's address, ISMS President Arthur R. Traugott, MD, said the Society "is pleased to see Gov. Edgar taking the lead on much-needed reforms of the Medicaid system. The proposals outlined by the governor offer exciting prospects for returning the Medicaid system to the type of program it was meant to be — one that provides quality, cost-effective medical care to the people of Illinois."

"As physicians, we are interested in getting good medical care to patients



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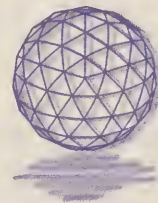
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air for students
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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • APRIL 8 1994

The state of
managed care



PAGE 5

Caps will be key election issue

By Kathleen Furore

With the March 15 primary results tallied, physicians must now decide which candidates will champion reform and other health care issues most important to medicine in the November general elections.

In the race for governor, Gov. Jim Edgar, who garnered 75 percent of the Republican vote in his run against Jack Roeser, will face Comptroller Dawn Clark Netsch, who came from behind to defeat Democratic challengers Attorney General Roland Burris and Cook County Board President Richard Phelan.

Edgar included a much-needed overhaul of the state's Medicaid system in his proposed 1995 fiscal budget. His proposal, scheduled to become effective April 1, 1995, retains fee-for-service options while increasing the number of managed care choices available to Medicaid patients. The governor's plan also

eliminates the Medicaid health facilities assessment program and calls for a change in state law to require more prompt reimbursement of providers. In addition, it proposes eliminating the backlog of Medicaid bills by refinancing the state's debt at lower interest rates.

According to Netsch's health care action plan, the Democratic challenger will expand coverage, control costs and reduce Medicaid abuse through a series of intermediate steps and will initiate what she calls a "fast-track process" to implement a comprehensive health care reform package by January 1996. The plan also notes that Netsch will focus short term on containing Medicaid costs by creating "smart cards" that will include Medicaid recipients' medical histories, establishing standards for quality care, allowing certified nurse practitioners to provide primary and preventive care services and receive Medicaid reimbursement for those services, and ensuring prompt payment of Medicaid

(Continued on page 15)

Smoking ordinance targets underage tobacco use

TOBACCO SALES: A Chicago vendor program may help Illinois comply with federal legislation. By Anna Chapman

[CHICAGO] On Feb. 9, the Chicago City Council amended a tobacco ordinance to strengthen the city's efforts to curb tobacco sales to minors. Introduced by Ald. Edward M. Burke, the ordinance decriminalizes the sale of tobacco to underage customers and places tobacco license regulation under the Chicago Department of Revenue. The new amendment will enhance the city's ability to discipline merchants for underage tobacco sales, according to Judy Rice, the department's director of revenue.

"We received numerous complaints that police didn't focus on this issue," Rice said, adding that the criminal courts are also overburdened with more serious offenses. As a result, merchants who sold tobacco to minors were not prosecuted, she noted.

As amended, the ordinance allows the Department of Revenue to issue citations for viola-

tions and oversee the process through administrative hearings, rather than through the criminal courts, according to Rice. Tobacco violations fall under the Department of Revenue's jurisdiction because it regulates vending licenses in Chicago, said Joel Monarch, deputy director of revenue. Violating the ordinance carries a \$200 civil penalty, and a vendor's license can be revoked if three or more violations occur within a two-year period, he added.

"Not to enforce a law like this is the wrong message to send," said Lawrence L. Michaelis, MD, president of the American Heart Association of Metropolitan Chicago. "Anything we can do to stop young people from smoking is useful. It is a terrible problem. The fact that we have tobacco companies purposefully trying to entice children into becoming

(Continued on page 12)

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1994 legislative session heats up



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James A. Turner, DO, a Marshall family physician (left), discusses physician concerns about maintaining high-quality patient care under health care reform with U.S. Rep. Glenn Poshard (D-Marion) during a March grass-roots physician lobbying effort in Washington.

Linda Bartlett

Grass-roots physicians travel to Washington

MEETINGS: Physicians unify to discuss reform issues with legislators. By Anna Chapman

[WASHINGTON] A diverse group of Illinois physicians took their health system reform message to Capitol Hill March 7-9 to educate legislators about quality of care issues. The Illinois doctors were part of a group of more than 800 physicians from 50 states who attended the AMA program "Partnership in Action: Uniting for America's Health," according to AMA officials.

The program included presentations by 10 members of Congress, including U.S. Reps. Newt Gingrich (R-Ga.) and Jim Cooper (D-Tenn.) and U.S. Sens. Bob Dole (R-Kan.) and Edward Kennedy (D-Mass.). In addition, Illinois physicians met with 19 lawmakers or their legislative aides during the three-day meeting.

Among the topics physicians discussed with legislators were antitrust relief and tort reform. Program participants agreed that those issues are vital to doctors' ability to provide

patients with quality care. Several Illinois participants noted that physicians showed a united front in Washington.

"We gave the politicians some idea that this is really important," said Dennis R. Caffery, MD, a family physician from rural Hopedale. "I hope it made a difference that we took the time to come out."

This was the first trip to Washington for some of the Illinois doctors participating in the program. They said they took time out from their practices to attend the meeting to ensure that their voices are heard in the reform debate. A few of the physicians had previously cultivated relationships with legislators from their districts.

One physician, Richard C. Trefzger, MD, a general surgeon from Bloomington, said he first met U.S. Rep. Tom Ewing (R-Bloomington) last year when the congressman participated in the ISMS

(Continued on page 12)



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Programs provide resource options for battered women

DOMESTIC VIOLENCE: The Illinois court system works with physicians and social service agencies to offer referrals to abuse victims. By Anna Chapman

[SPRINGFIELD] Several organizations have coordinated resources to help ensure that victims of domestic violence receive specialized services. The formation of the statewide Family Violence Coordinating Council was announced late last year by Illinois Supreme Court Chief Justice Ben Miller. In addition, he convened a broad-based steering committee to head the council, which includes members of the Illinois judiciary, domestic violence-prevention organizations and state agencies for public health, public aid and aging.

"The magnitude of the problem of family violence — the expense in lives, wasted potential and societal cost — demands the involvement of all levels of government," Miller said.

To promote effective prevention, intervention and treatment for victims, the council aims to coordinate services between agencies, departments and courts, said Janice DiGirolamo, victim services coordinator for the Administrative Office of Illinois Courts. Council members also hope to reduce violent incidents by improving agencies' overall response, she said.

Another council goal is furthering the development of three circuit-court-level family violence coordinating councils in the 9th, 10th and 17th judicial circuits. DiGirolamo said she hopes to start coordinating councils in all 22 Illinois circuits in the next five years.

"We've seen a tremendous improvement in services since the [circuit] council began," said 9th District Circuit Judge Stephen Evans. Previously, domestic violence services in his mostly rural circuit varied markedly from county to county, he said.

"Each circuit coordinating council has a steering committee and subcommittees, like the state council," said Leonard R. Yang, MD, director of the emergency department at Methodist Medical Center in Peoria. Dr. Yang chairs the 10th circuit coordinating council's health care provider subcommittee, which met for the first time on Jan. 13.

"Our goal is to provide a supportive environment for victims throughout the chain of medical care," Dr. Yang said, noting that he is encouraged to see collaboration by judges, law enforcement personnel, social service and government agencies and members of the clergy at the monthly meetings. "This is excellent because it's a roundtable. You can ask things you've always wondered about, because the people are right there."

The circuit councils have also provided workshops to help emergency physicians recognize family violence and learn what evidence might be needed for future prosecutions, DiGirolamo said. In addition, the councils provide physician information, such as the AMA guidelines on detecting and treating domestic violence victims.

Physicians should consider several issues when treating abuse victims, Dr.

Yang said. "It's important to create a safe and sensitive environment, because it's very difficult to take a true history. It's important to win their trust."

Dr. Yang said domestic abuse victims are often reluctant to seek help, and he recommended that physicians discuss the available options, instead of handing victims a list of resources. He also stressed the importance of follow-up. "It takes time, and the physician often has to be creative."

Sometimes it is difficult for physicians to determine whether a patient is a victim of domestic violence. Dr. Yang suggested asking patients indirect questions to facilitate discussion. "Ask how the children are doing. Then [ask], 'Do you fear for the children's safety?'" Physicians might also ask whether the patient was subjected to family violence as a child or whether family members have problems with alcohol. "Less threatening, indirect questions lead to gentle conversation," he said.

Physicians can also use physical signs as a guide in identifying abuse, said Barbara Finesmith, a Chicago attorney who helps victims obtain emergency civil

Gov. Edgar to address ISMS House of Delegates



Fresh off his primary election victory, Illinois Gov. Jim Edgar has agreed to speak at the 1994 ISMS Annual Meeting. Edgar is scheduled to address the House of

Delegates on Saturday, April 23, at 11 a.m. The meeting will be held at the Oak Brook Hills Hotel, 31st Street and Midwest Road in Oak Brook. All members are invited to attend.

In his recent budget address, Edgar called for an overhaul of the state's Medicaid system by increasing managed-care options while maintaining fee-for-service flexibility. A key component of the governor's plan includes

ensuring prompt reimbursement for Medicaid providers.

Edgar is completing his first term as governor. During his tenure, he has worked to keep state spending within available resources and has kept his pledge not to raise income taxes. The governor also strongly advocates tort reform, including caps on noneconomic damage awards in medical malpractice cases. In November, Edgar and Lt. Gov. Bob Kustra are running for reelection against Democratic nominees Comptroller Dawn Clark Netsch and state Sen. Penny Severns (D-Decatur).

For more information about the annual meeting, contact ISMS at (312) 782-1654 or (800) 782-ISMS, ext. 1160. ■

Chicago Medical School is renamed

[NORTH CHICAGO] The University of Health Sciences/Chicago Medical School in North Chicago has been renamed Finch University of Health Sciences/Chicago Medical School in honor of Herman M. Finch, CEO and chairman of the university's board of trustees. This is the first time a school of higher education has been renamed in honor of a living chairman, according to school officials.

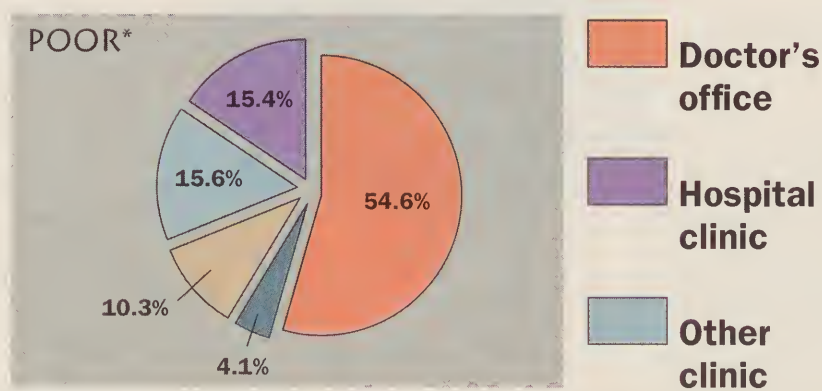
Finch, 79, created the University of Health Sciences/Chicago Medical School in 1967 by adding graduate and post-doctoral studies and a school of health sciences to the Chicago Medical School. It was the first institution in the country devoted to educating students for careers in the health sciences, school officials said.

Finch remains actively involved in the day-to-day operations of the university and is leading a new \$25-million fundraising campaign. "There had been a real effort on the part of the faculty to rename the school for years, and of course, I always resisted," Finch said. "But they persisted, and as I approached my 80th birthday, I lost my resistance. I'm overwhelmed."

"It is my hope that we will continue to be dedicated to our mission not only to train health care delivery professionals but to be flexible," added Finch, citing the university's two-year-old master's program for physician assistants as an example of how the school has adapted to meet changing needs. "We bob and weave as we go along and address ourselves to the needs of the nation. It's our source of pride, and I hope it doesn't cease." ■

PHYSICIAN FACTS

WHERE CHILDREN RECEIVE HEALTH CARE



*Family incomes less than \$14,343 per year

**Family incomes greater than \$28,686 per year

Source: 1991 National Health Interview Survey by the Center for Health Economics Research

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Smoking remains a problem for new mothers, babies

[HOUSTON] Many pregnant women give up smoking. But according to a pediatric pulmonologist at Houston's Baylor College of Medicine, most new mothers kick the habit for just nine months, then resume smoking after their babies are born.

"The mothers think they have 'saved' their babies from exposure to tobacco smoke [by refraining during pregnancy]," said Marianna Sockrider, MD, who treats children with asthma and other respiratory disorders. "But when they light up, the danger begins again."

Even if new moms want to stop smok-

ing permanently, temptations from other smokers often make that goal difficult to achieve, Dr. Sockrider noted. However, she recommended that mothers talk to smoking friends and relatives about the need for a smoke-free environment. Secondhand smoke can burn an infant's eyes, nose and throat; cause ear and respiratory infections; affect lung function; and possibly even contribute to crib death, impaired intelligence and slowed child development.

Dr. Sockrider also suggested designating a smoking area outside or in a well-ventilated room and reducing the number of cigarettes smoked as a first step toward abstinence. ■



MEDICAL STUDENTS from the University of Illinois at Chicago College of Medicine celebrate on Match Day, March 16, after learning which residency program they will join to continue their medical training.

EHS Health Care donates supplies abroad

[OAK BROOK] EHS Health Care, an Oak Brook-based network of hospitals and other health care providers, announced Feb. 23 that it gave nearly five tons of medical goods to Medical Donations for International Children (MEDIC). More than 9,500 pounds of supplies, including medication, baby formula, diapers, oxygen administration equipment and tubing, orthopedic supplies and intravenous tubing catheters, were sent to 21 locations around the world, according to EHS officials.

Most of the supplies were shipped to hospitals, orphanages and clinics in the Ukraine and Vietnam, as well as to a clinic on a Hopi Indian reservation in Arizona, officials said.

MEDIC collects medical supplies that would otherwise be discarded and ships them to organizations that benefit children in the United States and other countries, said Barbara Larson, RN, who founded MEDIC 15 years ago, after seeing firsthand the lack of supplies and equipment in orphanages and clinics in Korea.

Supplies are donated mainly by physicians and nurses who save unused items, Larson said. Typically, the donations are shipped along with relief supplies sent by other organizations, she said. In addition, travel agencies often connect MEDIC with groups traveling abroad. For instance, a group of graduate students carried medical goods to Cambodia in their luggage. MEDIC must rely on such acts of charity to get shipments to their destinations because of the organization's limited budget, Larson said.

Sometimes clinics around the world contact Larson and request specific items, she noted. Recently, a clinic in Colombia asked for medicine to treat worms. Although Larson could not secure a donation, she found a supplier who agreed to sell the medicine wholesale, she said.

Physicians who are interested in donating medical supplies may contact Larson at (708) 969-2537 or Jeanne Lang at (708) 260-9291. ■

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REPORT

FOR *Illinois Physicians*

MEDICARE PART B INDEPENDENT PHYSIOLOGICAL LABORATORIES: BILLING DIAGNOSTIC PHYSIOLOGICAL SERVICES

Under Medicare Part B, payment may be made for a diagnostic physiological service, furnished by a laboratory which operates independently of a hospital, physician's office or rural health clinic, if:

- the laboratory meets applicable state and local laws,
- the service is ordered by a referring physician, and
- the service is "reasonable and necessary" as defined in Section 1862(a)(1)(A) of the Social Security Act.

Effective March 1, 1994, this carrier began to cover services rendered by Independent Physiological Laboratories, under the following CPT codes:

GLOBAL SERVICE	TECHNICAL COMPONENT	PROFESSIONAL COMPONENT
93000	93005	93010
-----	93012	93014
93040	93041	93042
93224	93225 and/or 93226	93227
93230	93231 and/or 93232	93233
93235	93236	93237
93268	93268-TC	93268-26
93307	93307-TC	93307-26
93308	93308-TC	93308-26
93320	93320-TC	93320-26
93321	93312-TC	93321-26
93325	93325-TC	93325-26
93733	93733-TC	93733-26

GLOBAL SERVICE	TECHNICAL COMPONENT	PROFESSIONAL COMPONENT
93736	93736-TC	93736-26
93875	93875-TC	93875-26
93880	93880-TC	93880-26
93882	93882-TC	93882-26
93922	93922-TC	93922-26
93925	93925-TC	93925-26
93926	93926-TC	93926-26
93930	93930-TC	93930-26
93931	93931-TC	93931-26
93965	93965-TC	93965-26
93970	93970-TC	93970-26
93971	93971-TC	93971-26

An Independent Physiological Laboratory can bill for the global service or the technical component of the service. If the global service is billed by the laboratory, the professional component of the service must have been rendered by a physician, who could not have ordered the service. If the technical component of the service is billed by the laboratory, the professional component of the service can be billed only by a physician.

Physician HELpline

A 24-hour physician HELpline is available to link impaired physicians and their families with helpful resources. Contact the ISMS Physician HELpline at (312) 580-2499.

1994 legislative session heats up

BILLS: As legislators start to consider bills important to medicine, ISMS pushes for tort reform.

By Anna Chapman

[SPRINGFIELD] With the 1994 legislative session under way, Illinois lawmakers are considering many health-related bills, including the following:

Tort reform – Especially important to medicine is a tort reform bill, S.B. 1824,

prompted by ISMS and the Illinois Civil Justice League, the statewide coalition formed to seek improvements in the state's tort liability system. The bill, sponsored by Sen. David Barkhausen (R-Lake Forest), limits awards for noneconomic damages in tort suits, including

malpractice cases, to \$250,000 – an action long favored by physicians to help control health care costs in Illinois. The bill, which amends the Civil Practice Law article of the Illinois Code of Civil Procedure, includes several tort-related provisions, not all directly applicable to medicine.

Another ISMS-prompted bill, S.B. 1508, sponsored by Sen. Peter Fitzgerald (R-Palatine), also limits noneconomic loss recovery to \$250,000 and provides that written instructions about the cap be given to the jury. Both bills are currently awaiting readings in the Senate Rules Committee.

Medicaid – A number of bills affecting the Illinois Medicaid program have been introduced in the legislature following Gov. Jim Edgar's recent pledge to overhaul Medicaid by creating a managed care system and targeting fraud and abuse. Edgar's proposal calls for expanding managed care choices for Medicaid patients while retaining fee-for-service options. The governor is expected to introduce legislation next month that details his plan.

On March 23, the Senate Public Health and Welfare Committee passed an amended version of S.B. 1147, sponsored by Sen. Carl Hawkinson (R-Galesburg). The bill originally required identification photos on Medicaid eligibility cards, but the amended version calls for statewide implementation of a Medicaid eligibility verification system. Each Medicaid participant will be issued a health care card containing electronically coded information, such as the recipient's eligibility and benefit status, payment responsibilities, updated patient records and medical history, according to the bill. To receive medical care, recipients will be required to present the Medicaid card as well as another photo ID. All providers and medical care sites participating in the verification system will be linked electronically to the Illinois Department of Public Health's computer system. The bill also directs IDPA to develop safeguards aimed at protecting recipient information from misuse or unauthorized disclosure.

S.B. 1147 also requires physicians to include their name, the patient's name and a diagnosis on all Medicaid claims. ISMS does not oppose this bill.

S.B. 1459, sponsored by Sen. Howard Carroll (D-Chicago), requires, rather than allows, IDPA to implement managed care programs for chronically ill children, the elderly and disabled people.

Similarly, S.B. 1269, sponsored by Sen. Jesus Garcia (D-Chicago), requires IDPA to implement a pilot program enrolling in an HMO certain Medicaid recipients, including chronically ill children and elderly and disabled people.

S.B. 1480, sponsored by Sen. Judy Baar Topinka (R-North Riverside), requires IDPA and the Illinois Department of Insurance to study the feasibility of allowing HMOs to provide acute care to Medicaid long-term care recipients.

H.B. 2682, sponsored by Rep. David McAfee (D-Summit), calls for charging individuals with a Class 3 felony if they abuse Medicaid privileges by receiving

more medical services than they need or by receiving services more often than they need.

S.B. 1526, sponsored by Sen. Laura Kent Donahue (R-Quincy), which amends the Medicaid article of the Public Aid Code, provides that IDPA require copayments from Medicaid recipients for certain medical services, including physician services.

Licensing – ISMS opposes the following four bills affecting the licenses of allied health professionals. One expands the scope of practice for Illinois optometrists. This bill, S.B. 1207, sponsored by Sen. Frank Watson (R-Carlisle), amends the Illinois Optometric Practice Act of 1987 and expands optometrists' use of ocular pharmaceutical agents to include therapeutic treatment of patients.

S.B. 1262, sponsored by Sen. John Cullerton (D-Chicago), would have expanded the scope of practice of clinical psychologists to include diagnosis. Clinical psychologists are now licensed to evaluate and treat, but not diagnose, various mental, emotional, behavioral and nervous conditions. S.B. 1257, also sponsored by Cullerton, states that clinical psychologists may not be prohibited from obtaining hospital privileges or staff membership by Illinois law, agency rule or institutional bylaw. Similar bills were introduced and defeated in the 1993 spring legislative session. Both bills were defeated in Senate committee.

H.B. 3256, sponsored by Rep. Jan Schakowsky (D-Evanston), requires the Illinois Department of Public Health to certify midwives who are not licensed by the state. Currently, all professionals are licensed through the Illinois Department of Professional Regulation, not IDPH. The bill also calls for the establishment of an 11-member IDPH advisory committee to implement the Midwife Certification Act.

Public health – Motorcycle and bicycle helmet regulations and firearm control bills made the legislative agenda. H.B. 2551, sponsored by Schakowsky, requires every motorcycle operator and passenger to wear a helmet.

H.B. 3520, sponsored by Rep. Jeff Schoenberg (D-Wilmette), and S.B. 1236, sponsored by Cullerton, require children under 16 to wear helmets while riding a bicycle. The bills impose a \$30 fine for violators. The money collected will be used to help purchase helmets for children in low-income families.

H.B. 2695, sponsored by Rep. Clement Balanoff (D-Chicago), charges individuals with a petty offense if they are responsible for a firearm and if a child under 14 gains access to it without parental permission and displays it in a public place.

S.B. 1489, sponsored by Sen. Bruce Farley (D-Chicago), directs IDPH to establish an Osteoporosis Prevention and Education Program and create an advisory council to help implement the program.

S.B. 1501, sponsored by Sen. Margaret Smith (D-Chicago), requires hospitals to promote breast feeding as the preferred method of nurturing an infant. It also excludes breast feeding as an act of public indecency. ■

Watch for your next issue of Illinois Medicine, with coverage of the Senate hearing on S.B. 1207. ISMS President Arthur R. Traugott, MD, will testify regarding the potential harm of this bill.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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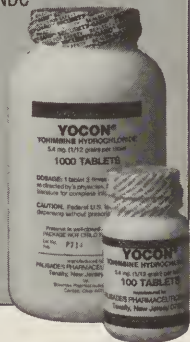
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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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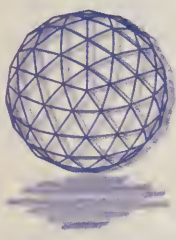
The state of managed care

States with heavy HMO and PPO penetration are adjusting to changes in health care delivery.

By Kathleen Furore

Managed care, with its focus on cost-containment, is certain to play a major role in the delivery of health care, whatever the specifics of system reform. According to an October 1992 article in *Texas Medicine*, a nationwide survey by the Chicago-based SMG Marketing Group showed traditional fee-for-service patients dropped from seven out of eight in 1984 to just one in five in 1991. The survey also projected that by 1997 only 12 percent of doctor-patient contacts will be on a fee-for-service basis.

MANAGED CARE



More recently, the *Marion Merrell Dow Managed Care Digest's* 1993 HMO and PPO editions published 1992 statistics that underscore the growing popularity of managed care: A total of 562 HMO plans enrolled 43,741,115 (or 17.3 percent of the U.S. population), up 8.3 percent from the 15.9 percent penetration tracked in 1991. And an estimated 2,578 PPO networks reported 58,038,066 workers eligible to use PPO services for their general medical and surgical health care benefits, up from 1991's total of 39,031,374. Those PPO numbers even excluded eligible workers' dependents and those participating in workers' compensation PPOs.

To kick off an *Illinois Medicine* series on managed care, the following overview highlights managed care activities in California and Texas.

California

The state has an extensive background in managed care — from the Kaiser Permanente Health Plan that debuted during World War II and was expanded in 1945, to comprehensive HMO regulation in 1976. Consequently, California is often considered a working laboratory for the managed competition theories advanced by many proponents of health care reform, according to a March 1994 article in *California Physician*.

Recent data show good reason to view California as a model for managed care: 1992 statistics reported in two 1993 *Marion Merrell Dow Managed Care Digests* placed California second only to Massachusetts in HMO penetration, and first ahead of Texas and Florida in the number of PPO networks available to health care consumers. According to the report, 34.4 percent of the state's population participated in 46 operating HMO plans, bringing total enrollment to 10,420,000. California was also serviced by 101 local and national PPO networks — nine more than in Texas and six more than in Florida.

Although managed care has caught on quickly with California consumers, Jane Burns, policy development coordinator for the California Medical Association, said physicians only recently have begun buying into the concept of managed care. She noted, however, that the trend

toward HMO and PPO participation has not been problem-free.

"There initially was a lot of reluctance here [by physicians] to get involved with managed care. Now there's a real rush to join plans because physicians see their patients slipping away," Burns said. "But in the rush to sign contracts, doctors are finding the contracts are coming back to bite them. They may find that reimbursement rates aren't high enough because there aren't enough patients or that they're being terminated without cause by the plans."

To help answer questions and solve problems related to managed care, CMA offers its members a comprehensive menu of publications and services, Burns said. Those managed care resources include a physician's contracting manual, a contract review service, a summary of state HMO laws affecting physicians, an action plan for physicians terminated by managed care plans, a brochure to help patients choose health care coverage, reimbursement assistance for members who experience problems with their plans, a handbook detailing laws that affect California medical practices, guidelines on how to appeal denied and/or unfairly paid claims, and managed care workshops on such topics as practice profitability and the legal pitfalls of contracting with managed care organizations.

In addition, Burns said CMA is very active in the state legislature. "Last session, we helped pass a law that says managed care organizations cannot terminate physicians for advocating for appropriate patient care." She said that previously, some plans had denied continued authorization for hospital stays and/or treatment recommended by physicians, who were then sued and often terminated from plans when bad outcomes occurred.

CMA is also examining the possibility of creating its own physician-controlled health care organization, Burns noted.

Texas

An October 1992 *Texas Medicine* story said the number of consumers enrolled in managed care plans was growing rapidly. Data from the *Marion Merrell Dow Managed Care Digest* showed 92 national and local PPO plans serving the state in 1992, putting it just behind California and Florida in PPO penetration. That same data placed Texas 26th in the nation in HMO participation: In 1992, the state had 11.5-percent penetration, with 1,988,700 individuals enrolled in 26 HMO plans. Although no statistics are available regarding point-of-service plans, the *Texas Medicine* article said some experts have identified them as the fastest-growing segment of Texas' managed care market.

But those statistics don't paint a completely accurate picture of managed care in Texas. According to Mark Richardson, *Texas Medicine's* associate editor for economics, Austin and Houston are the only places managed care thrives. "Those cities are the two chunks of the state where managed care has a foothold. Austin is really an island of managed care. It's practically nonexistent in the rest of the state, especially the rural areas."

As managed care participation has increased, so too have the problems Texas physicians are encountering in contracting with and practicing under managed care plans, said Karen Batory, director of the health care delivery department of the Texas Medical Association. Of great concern have been the hiring and termination practices of managed care organizations, she noted.

"We've had a big problem here with physicians not being able to get into

networks or being terminated by the plans," said Batory. "Plans have the money and power, and physicians are treated as commodities." As a result, TMA is pursuing state and federal legislation that would require HMOs and PPOs to give physicians due process, Richardson said.

TMA has also implemented several programs focusing on managed care. Batory said the association began meeting with carriers of large managed care companies approximately two years ago "to talk about hassles that managed care doctors had communicated to us."

"The doctors needed a more level playing field, so we brought members of the managed care industry to the table with us," she added.

TMA has also conducted managed care checkups to monitor physicians' satisfaction with and concerns about the managed care plans in which they participate, Batory said. "We work with county medical societies and select up to 10 plans. Then we ask 500 to 600 doctors per market to rate the plans on aspects like the fairness of reimbursement, patient access to medical services, paperwork requirements and the feedback they get from the managed care companies."

In a recent Houston market checkup, 88 percent of the 535 physicians surveyed were satisfied with their PPOs, 73 percent with their point-of-service plans, and 69 percent with their HMOs, Batory said.

The association's Managed Care Resource Program also offers a managed care contract evaluation service; a Dun & Bradstreet credit advisory service that reports managed care companies' financial histories and credit risk scores; access to managed care consultants; consultations with TMA experts on payment, coding and utilization review; a hassle factor log program that lets doctors inform the association about problems with insurance companies, Medicaid, Medicare, regulatory agencies and utilization review firms; a hot line that offers weekly updates on congressional action on health system reform; and a series of seminars to debut this spring that will cover aspects of forming IPAs, according to Richardson.

ISMS' Medical Leadership Initiative yielding results

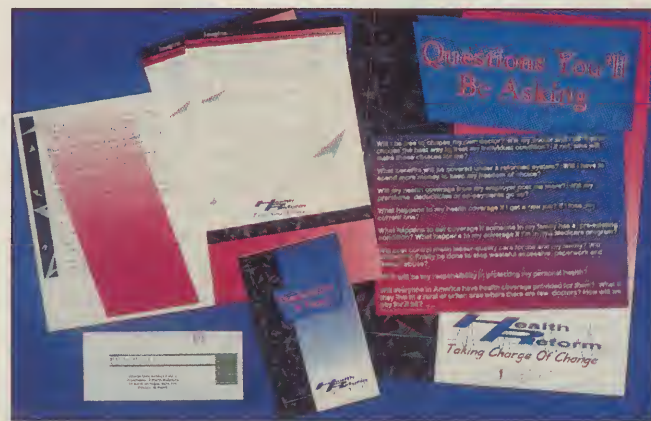
Throughout 1994, ISMS has sent fact-finding teams around the state to assess physicians' needs in the changing medical marketplace. And these meetings, held under the auspices of the Medical Leadership Initiative, are producing results.

To date, teams have met with physicians at about 70 county medical society and hospital medical staff gatherings. The information gleaned from physicians at these meetings is being studied and used as the basis for creating new ISMS programs aimed at helping doctors adjust to the increasingly complex health care delivery environment.

ISMS is also in the process of commissioning a feasibility study to assess the pros and cons of an ISMS physician network. The study will examine all managed care options, including HMOs, PPOs, IPAs and clinics without walls.

In addition, ISMS has stepped up its Washington Presence program to help achieve critical elements of health care reform. Last month, a group of Illinois physicians joined ranks with about 800 physicians from around the nation to lobby for antitrust and tort reforms on Capitol Hill. Illinois doctors will continue these key contacts by meeting with Washington lawmakers in their home districts in the next few months. To participate, physicians may contact ISMS' governmental affairs division.

Member physicians also recently received copies of ISMS'



new patient education kit, designed to facilitate physician-patient discussions about the essential components of health care reform. Written in an easy-to-understand format, the Health Reform Action Kit answers patients' most commonly asked questions about reform and explains how single-payer, government-run health care would harm the quality of patient care.

For more information about ISMS services or to set up a Medical Leadership Initiative visit in your area, contact the Society at (312) 782-1654 or (800) 782-ISMS.

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EDITORIAL

Getting the message to patients

It seems that consumers have heard the message about the potential problems of the Clinton plan. That point has been substantiated in recent surveys. A Republican polling firm surveyed 800 adults and found that 63 percent believed that the president has withheld certain details of his plan. Fifty-two percent said they are not comfortable entrusting their care to a government-run plan. And 87 percent would oppose a plan that failed to guarantee physician choice. In the final analysis, 68 percent oppose the Clinton plan.

In another survey, released by the *Wall Street Journal*, Peter Hart and Robert Teeter interviewed 1,503 adults. Forty percent were "very satisfied" with their health care, and 60 percent said that it would be acceptable if Congress did not pass a health reform bill in 1994. Respondents characterized the current system as having major problems but not being in a crisis. In rating the sources of health reform information they had received, respondents could choose from their doctor, their local newspaper, their employer, their congressman, President Clinton and labor unions. The group that received the most "very important" ratings was physicians.

Also in the Hart-Teeter survey, respondents were asked: "The following groups will try to change the Clinton plan. Do you feel more confident about their ideas or President Clinton's ideas?"

Among the choices were the AMA, major insurers, hospital groups, the Chamber of Commerce and labor unions. The only group to receive more votes than the president was the AMA, with a 41-percent confidence rating.

Finally, *Fortune* magazine detailed the potential results if businesses took a wrong turn in following the Clinton plan and ended up with fines. Those penalties include \$5,000 or more for employers who fail to pay their premiums, \$10,000 for doctors or insurers who don't use the standard benefit form, \$100,000 for late reporting by big businesses that self-insure, and up to five years in jail for any employee or employer who makes false statements to a health plan. The magazine says that for small businesses that can't afford to retain legal counsel, the plan would be a "disaster."

We can draw some positive conclusions from these surveys and the media coverage: The word is out about the problems the Clinton plan would cause for patients and business, and respondents have expressed confidence in information they receive from their physicians and the AMA.

So don't be reluctant to discuss reform with your patients. By now, you should have received ISMS' Health Reform Action Kit. Use it as a basis for answering patients' questions and addressing their concerns. They are listening.

PRESIDENT'S LETTER

Allied health professionals are part of the team

By Arthur R. Traugott, MD



As patient advocates, we must see that quality of care is maintained in the critical areas of prescription and diagnosis.

The scope of practice of allied health care professionals is a subject that arises periodically and has recently resurfaced in the media and the state legislature. In a February issue of the *Nursing Spectrum*, I was interviewed about the role of advanced practice nurses. My remarks focused on the need for a team approach to medicine.

Nurse practitioners and other nurses with advanced degrees can help increase the access to care in a community — by following up after physician visits and conducting well-baby exams, for instance. There's no question that these skilled practitioners play an important role in the delivery of health care. However, diagnosis of illnesses and prescription of medications should be performed only by physicians, who have the appropriate training and experience. Our state's Controlled Substances Act does not include advanced practice nurses among the medical professionals who can prescribe.

Prescribing has become extremely complex today. The number of new drugs increases all the time, and the uses of those medications expand as well. The professionals who prescribe must have additional education and training. Advanced practice nurses, however, can contribute by monitoring the effects and side effects of medications, according to established protocols.

As patient advocates, we must see that quality of care is maintained in the critical areas of prescription and diagnosis. It is in our patients' best interest to identify and treat health problems as soon as possible, and physicians have the necessary qualifications to perform those functions.

In any team effort, each member has a job to do; the health care delivery team is no different. A well-coordinated effort and strong

cooperation are necessary for the team to function optimally. Nurse practitioners and supervising physicians should collaborate in deciding which protocols nurses will implement. And advanced practice nurses should meet regularly with physicians so that doctors may review patient charts and supervise the care given.

In this year's legislative session, several bills regarding scope of practice have already been introduced. One of them would expand optometrists' use of ocular pharmaceutical agents to include therapeutic treatment of patients. By the time you receive this issue of *Illinois Medicine*, I will have testified in Springfield about the harm that could result from passage of this bill.

Two bills, already defeated, would have expanded the scope of practice of clinical psychologists to include diagnosis and would have allowed psychologists to obtain hospital privileges or staff membership by Illinois law, agency rule or institutional bylaw.

Many allied health professionals are seeking greater autonomy and the ability to perform activities that can currently be done only by physicians. But the indisputable fact is that physicians simply have more extensive and intensive education and experience from which to draw. Other health care professionals are important for what they contribute to the team, but they should not try to duplicate those responsibilities with which physicians have been charged, by law and by their patients.

Health care is heading toward a managed care system that requires all providers to operate as a well-orchestrated team. That team will work best if each member focuses on mastering his or her own particular role and works cooperatively to complement other team members.

GUEST EDITORIAL

Health care reform without doctors won't work

By Barbara Reynolds

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Without doctors to serve the poor, health reform will be as effective as an athlete running in leg irons.

Yet even as the Clinton administration focuses attention on health, government policies are driving doctors from poor areas. Listen to Norm Clement of Detroit's Dental Survey of America: "Why should doctors treat the poor when the government programs that insure them underpay, plus carry the real threat that innocent doctors can go to jail?"

A Feb. 9 article in the *Journal of the American Medical Association* focused on the flight of doctors and hospitals from inner cities. In some cities, affluent areas may have one doctor per 300 patients, while poor areas have as few as one doctor per 15,000.

Some community health advocates

blame policies that have made the inner city hostile. They cite overzealous prosecutors for getting carried away with trivial offenses and using drug laws written for the Pablo Escobars to nail Marcus Welbys.

"Inner-city providers are penalized more than those in the suburbs with fewer federally funded poor patients. Doctors and pharmacists are being jailed for prescribing painkillers that have been criminalized under new drug laws," says Christopher Pencak, a lawyer-pharmacist. Those factors aided in the decline of Detroit independent pharmacies from 600 in the 1960s to 40 today, he says.

Pencak points to Carol Sims Robertson, a Detroit physician, a mother of two children, as the symbol of a system run amok. She is in jail for dispensing prescription drugs that were misused by drug addicts. Because of mandatory minimum sentencing laws, she is serving 12 years, while violent criminals are paroled. AMA Senior Vice President Kirk Johnson

calls her a "heroine of what's wrong with the drug laws" and plans a campaign to help embattled physicians.

Fred Williams, one of the first black doctors to practice in Panama City, Fla., where he treated abused women and their children free, is bankrupt from legal fees and also may be on the way to jail.

Dr. Williams was found guilty, by an all-white jury, of overbilling \$981 over 10 years, his lawyers say. His appeal says he was convicted on laws that didn't exist until after he was indicted. "If the jury had known of the discrepancies and understood medical law, we wouldn't have convicted an innocent man," Charles Myers, a juror, told me. But Tim Jansen, the prosecutor, says the evidence against Dr. Williams was "overwhelming."

It seems criminal that doctors and patients are punished as pleas for community service work go unanswered.



GUEST EDITORIAL

Market is already doing it

By David Lawrence, MD

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Whether one agrees with the underpinnings or scope of the health care reform proposals coming out of Washington, at least two facts remain to the dismay of managed care critics: First, managed care already has fueled the engine of reform in the marketplace and second, it has proved its ability to deliver quality health care while containing costs. The greatest value of managed care, particularly HMOs, lies in its approach to organizing and coordinating care. This approach – so greatly misunderstood by the critics – involves changing the economics and delivery of health care so it is possible to provide the right care at the right time and place.

In a group practice HMO, for example, the doctor can truly be a patient advocate because individual clinical decisions do not directly affect his or her income. Knowing patients will not be financially burdened also frees the physician to base clinical decisions on what is medically appropriate, and to provide care in the setting that best meets the patient's needs. An HMO's financial incentives and rational structure ensure quality and contain costs.

Critics of managed care raise the specter of medical decisions made by a bureaucracy concerned only with the health of its bottom line. On the contrary, group practice HMOs – closely knit groups of physician colleagues who practice together, coordinate care, and learn from one another – have been working to reform health care for several decades by putting the patient at the center of all decisions, making health the

bottom line.

How does the theory translate into practice? Evidence indicates that organizing and coordinating care to keep people well improves quality and contains cost. Here are a few examples from my own organization, Kaiser Permanente:

- Physicians, health educators and nurses have joined together to create a support system that helps families understand, predict and control a child's asthma. While the national average for repeat hospitalizations for children suffering from asthma is 20% to 30%, at several Kaiser Permanente facilities this figure is now down to just 5%. Hospital days for asthma treatment are down by 70% over a two-year period.

- The first step in reducing heart disease and stroke is identifying people at risk. In the past five years, we screened 93.1% of our "at risk" Northern California members for hypertension. The effectiveness of our treatment following screening is demonstrated by the low number of our patients who suffer strokes relative to statistics from other California hospitals – 125.7 per 100,000 people compared with 164.1 statewide.

- Our performance in Northern California in immunization against common childhood illnesses (measles, mumps, diphtheria) is well above the state average. In the case of hemophilus influenza type B, which can cause bacterial meningitis, we immunize children at a rate more than twice the state average. Statewide, about 70% of children under age 2 have been inoculated against measles, mumps and rubella, compared with 93.8% of Kaiser Permanente members.

- Our premature-birth prevention programs include frequent prenatal visits, nutrition counseling, and having a nurse telephone the mother frequently to

assess warning signs of premature labor. By putting the patient at the center of care, we have prevented one in four premature deliveries. Neonatal intensive care days have been reduced 25% – days that cost more than 10 times that of a full-term newborn nursery. The savings in hospital costs alone translate into more than \$1 million a year in our Washington, D.C., region.

These examples illustrate what HMO physicians can do for their patients. But do they contribute to a more efficient marketplace?

- A new KPMG Peat Marwick study found that HMO premiums increased 40% less from 1988 to 1993 than premiums for fee-for-service plans and 32% less than preferred-provider organizations. Savings were achieved while providing more preventive services, lower out-of-pocket costs, and generally more comprehensive benefits.

- According to the latest Foster Higgins survey of 1993 health benefit costs, traditional indemnity plans remained the most expensive plans, averaging \$3,500 per employee nationally, while HMO plans averaged only \$3,276. In California, where HMO penetration is highest, indemnity plan costs increased 8.4% to \$3,743 per employee and HMO costs increased only 4.9% to \$2,926 per employee.

- Growing numbers are choosing HMOs as an alternative to fee-for-service medicine – 45 million Americans last year alone. A new survey by KPMG Peat Marwick found that 74% of mid- and large-sized employers are offering HMOs.

- Employees enrolled in HMOs offered by their employers are as satisfied with their plans as are members of traditional fee-for-service plans, according to polls by Gallup and National

Research Corp.

Successful market-based reform should not be measured by cost savings and increased enrollment in managed-care organizations alone, however. Legitimate reform must provide coverage and access for the uninsured or underinsured, guarantee the quality of medical care, provide a broader choice of health plans (including free-choice-of-physician plans) for individuals, and equitably spread the cost of financing America's health care bill.

Indeed, some of these reforms are already occurring at the state level and through voluntary actions by health plans. More reform is needed, however. If we do not improve the health status of all Americans, and if we do not correct the underlying structural flaws and skewed incentives of traditional insurance that prevent our health system from serving everyone, reform ultimately will fail. It is precisely these problems that organized, coordinated care approaches like Kaiser Permanente's have addressed.

Does our model represent a cure-all, a reform panacea? We would never make such a claim. We believe people should have choices. More and more Americans are turning to HMOs because the status quo clearly is not working. Health care largely remains a cottage industry made up of thousands of independent entities. Many who have insurance coverage find it confusing and uncertain. When future generations look at the accomplishments of health reform, I hope they do not see that we perpetuated a fragmented, inefficient, unfair system that leaves many without the health care they need.

Dr. Lawrence is CEO of Kaiser Foundation Health Plan Inc. and Kaiser Foundation Hospitals.

General Assembly
considers tort reform bills

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ISMIE Update

ISMIE extends
telephone
service hours

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MALPRACTICE ROUNDUP

Illinois court upholds HIV statute

On Jan. 20, the Illinois Supreme Court upheld a state statute making it a crime for HIV-infected individuals who know they carry the disease to transmit the virus through intimate sexual contact. According to a case summary in the *National Law Journal*, the court said the statute does not violate carriers' freedom of speech or association, as charged in *The People vs. Russell*.

In that case, the state filed a criminal complaint against the defendant, charging she knew of her HIV-positive status but failed to inform the partner with whom she had consensual sex. The trial court ruled that the statute making such action a criminal offense was unconstitutional because it violated the defendant's free speech and association rights. However, the high court reversed that decision and held that the statute did not violate the federal or state constitutions. ■

Taking patients when leaving HMOs

In a case of special interest to physicians who practice in HMOs, a Florida appeals court ruled that a physician who left an HMO was free to take his patients with him because of the overriding importance of the physician-patient relationship.

In *Humana Medical Plan Inc. vs. Jacobson*, the court said that a clause in the contract between the physician and the HMO was unenforceable because it "needlessly hindered the continuation of [the doctor's] existing and successful doctor-patient relationships by driving a financial wedge between the doctor and his patients."

The court also ruled that "patients are not the property or chattel of an HMO" and that Florida's public policy "is violated when the business relationship an HMO has with its affiliated doctors interferes with something as fundamental as the doctor-patient relationship." ■

Dermatologist failed to diagnose cancer

A plaintiff received a \$25,000 award because of a dermatologist's failure to refer him to a surgeon, according to the medicolegal digest *The Citation*. The patient consulted his dermatologist because of a red area on his cheek. The physician sent a specimen to a pathologist, who identified the tissue as "almost certainly a Merkel cell tumor."

When the patient returned to the dermatologist three weeks later, the area had become larger and redder. But at that visit and a subsequent one a month later, the physician told the patient that the area was healing. At the final visit, a month later, the area was "multinoduled," and the dermatologist told the patient he didn't know what to do. The patient then saw another dermatologist, who immediately referred him to a surgeon. Two surgical procedures were performed to remove the cancer.

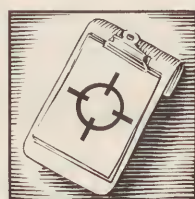
In finding for the plaintiff, a trial court cited evidence that the first dermatologist's failure to send the patient to a surgeon may have caused further injury to the patient. ■

Case in Point

Physicians can help, hinder their own legal defense

By Kathleen Furore

Being sued for malpractice is every physician's nightmare. Yet it is increasingly becoming an unavoidable fact of life, as



physicians strive to deliver high-quality, cost-effective medical care in a litigious environment. After reporting the suit to their malpractice insurer, physicians who face a lawsuit can do some things to help their defense.

"A great place to begin is to take the Boy Scout approach — be prepared," advised Kevin Glenn, senior partner at Chicago's Bresler, Harvick & Glenn. "When your lawyer comes in to meet with you, you should have read the complaint and the records, so that you can relate to the allegations being made against you."

Glenn also noted that defendant physicians should read the 622 report, which is developed by reviewing physicians and must be attached to all malpractice complaints. "That report lists the reasons the malpractice action is meritorious, and those reasons become the cornerstone of the plaintiff's position," Glenn explained.

Physicians should also know the standards of care that apply to the situation at hand, said Bob Baron, a defense attorney with Rooks, Pitts & Poust in Joliet. "Not only should they know about the patient and the event that occurred before their meeting with the lawyer, but they also should have looked up what the standards of care are — not just what they think they are. In general, their conduct should be reviewed against standards in published, accept-

ed textbooks. If a physician says something, I rely on it. And if it's incorrect information, it can get us on the wrong track."

Also stressing the importance of preparation and attorney-physician interaction, Alfred J. Clementi, MD, chairman of the ISMIS Board of Directors, suggested that physicians "educate the attorney about the issues involved in the malpractice case. Send articles that will help in preparing the defense."

These articles, gleaned from medical journals and Medline searches, can help attorneys understand the medical aspects of malpractice cases. Pertinent information would include the scientific aspects of the disease or injury processes and their effects on the body, as well as the names of consultants in the appropriate medical specialty, as long as there is no element of self-interest in the choice of consultants.

Physicians should turn to their insurer and develop rapport with their legal counsel as much as possible, continued Dr. Clementi. "Use the insurance company; it has programs that can help take care of the emotional issues as well as the actual malpractice defense. And make sure you're very comfortable with your attorney. If you're unhappy, share your feelings with the claims manager."

The ISMIE seminar "Taking Control: Managing Your Malpractice Lawsuit" provides information about how physicians can act as their own advocates. For information about the seminar, policyholders may call (312) 782-2749 or (800) 782-4767.

DEPOSITIONS ARE VITAL to the defense of malpractice lawsuits. That's why the experts interviewed said physicians can assist their defense by diligently preparing for their own depositions and attending the depositions of plaintiffs and expert witnesses.

"I try to counsel all doctors to attend any depositions that happen before theirs, especially if it's the first time they've been involved in a suit," said Glenn. "The very first deposition they attend shouldn't be their own. And I advise them to go to the plaintiff's deposition, especially if it's a case of the plaintiff's word vs. the doctor's. It's difficult [for the plaintiff] to look a doctor in the eye and call him or her a liar. And if the [defendant] doctor is there, he or she can tell me if the plaintiff's story is accurate."

In addition, physicians should review documentation. "Too many physicians look at only their own material," noted Glenn. They should also review the hospital charts and the records of the co-defendant and prior treating and subsequent treating doctors, he advised. "A lot of information can be obtained from these other materials."

Attending a plaintiff's deposition can also help a physician feel more involved in the defense, and it enables the defendant to hear a plaintiff's testimony before the trial, Glenn said. A physician's presence at this deposition can even relieve stress and help the doctor feel more prepared for the detailed questioning that will come from the plaintiff's attorney, according to ISMIE risk management experts.

MEDICAL RECORDS are always important to physicians. In malpractice litigation, the charts physicians keep — and the way they keep them — can make or break the defense, said ISMIS general counsel Saul Morse. "It is necessary to have records to establish the nature of care that is provided and to build a base of trust in the finder of fact. Few, if any, malpractice cases can be

(Continued on page 9)

ISMIE extends telephone service hours

In an ongoing effort to provide comprehensive policyholder services, ISMIE has implemented a new program to expand the hours during which policyholders can receive information through its toll-free number. The Service-on-Call program enables policyholders to receive ISMIE staff assistance through the 800 number Monday through Friday from 8 a.m. to 6 p.m., according to Harold L. Jensen, MD, chairman of the ISMIE Board of Governors.

The program began April 7, with ISMIE staff manning the phone lines for an additional one hour and 45 minutes each day, Dr. Jensen said. "ISMIE recognized the need to accommodate physicians' demanding schedules. As a result, we extended the hours for telephone coverage as a convenience to our policyhold-

ers. Although policyholders may leave a recorded message at any time, this new program makes it easier for physicians to speak with a qualified staff member when they call ISMIE. This is just another step underscoring the commitment we've made to our insureds through the Physician-First Service initiative."

Dr. Jensen added that through the Service-on-Call program, physician policyholders may continue to call ISMIE at (800) 782-4767 or (312) 782-2749 to report a claim, discuss protection

options and other services, express concerns, or ask questions about underwriting or claims issues.

Service-on-Call joins ISMIE's roster of other services, including the ISMIE Clinic Option, the defendant reimbursement program and risk management seminars, Dr. Jensen noted. "We've been building on our Physician-First Service campaign since its inception almost three years ago. We are continually working to strengthen the initiative by adding services that will benefit policyholders." ■

ISMIE Service-on-Call



(800) 782-4767 or (312) 782-2749
8 a.m. to 6 p.m.

Case in Point

(Continued from page 8)

prosecuted or defended without accurate medical records."

Especially crucial to the defense, added Morse, is that physicians never alter their patients' medical records for any reason or under any circumstance – no matter how benign the changes may seem. Morse cited *Harris Trust & Savings Bank vs. Ali*, in which the court stated, "It is textbook law that the fabrication of false documents is an admission by conduct in that the person fabricating the document gives grounds for believing his case is weak." In addition, the Illinois Criminal Code of 1961 states that altering medical records and using them in a lawsuit are grounds for forgery or perjury, according to Morse. And the Medical Practice Act of 1987 considers "willfully making or filing false records or reports in his or her practice as a physician grounds for discipline."

For those who think no one will detect a few minor changes or additions to a patient's record, Baron cautioned: "I had a case in which the lawyers asked for the original records and for ink samples. There are very well-regarded people who can age ink – find out, for example, if a 1987 entry was made with 1992 ink. And remember that someone may have a copy of the record before it was altered – maybe a lawyer got a copy two or three months before the suit was actually filed."

Physicians should also avoid talking to subsequent treating physicians after a lawsuit has been filed and shifting blame onto other defendants, according to ISMIE risk management experts.

"Talking in detail with anybody other than their attorney – subsequent treating physicians, the patient's attorney, anyone involved with the care of the patient – is dangerous," said Dr. Clementi.

Defendant physicians are allowed to contact such witnesses only through formal discovery channels, said Glenn.

Directing blame toward other defendants is tantamount to admitting that a physician-caused misadventure did indeed occur, Glenn added. "Two defendants pointing fingers at each other is the ideal position for any plaintiff to be in. They're admitting that something went wrong and making a case for the plaintiff. We take the position that the plaintiff has the burden of proving something went wrong. So why do we want to give the plaintiff a break?" ■

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INNOVATIVE CARE

A breath of fresh air for students and sick kids

Through an arts program at the Rehabilitation Institute of Chicago, children receive therapy as play.

BY JANICE ROSENBERG

Medical students clap their hands and sing "La Bamba" to a Latin American beat. A boy in a wheelchair pounds a set of bongo drums. A tiny girl who minutes ago was being held upright by a "prone stander" sits on a student's lap, tentatively shaking a tambourine.

Just your run-of-the-mill Monday afternoon in medical school? Hardly. Yet the 12 Northwestern University Medical School students gathered on the fifth floor of the Rehabilitation Institute of Chicago for the "Arts for Children in Hospitals" program are learning as much as they would in any regulation classroom. They are caring for children, observing how the arts make a difference in patients' lives and finding out a bit about themselves in the process.

"I'm all in favor of active learning after two years in the classroom," said Jordan Shavit, 23, a second-year student. "I took the course because I thought it would be fun. I'm interested in pediatrics, and I'm very interested in the arts."

Arts for Children in Hospitals was designed by Very Special Arts, a Washington, D.C.-based international organization that provides programs in creative writing, dance, drama, literature, music and the visual arts for individuals with physical and mental disabilities. Piloted at Georgetown University School of Medicine in 1990, it uses hands-on experience to teach students the value of using arts activities with pediatric patients. The program is currently in place at nine medical schools including Harvard Medical School, Ohio State University College of Medicine and the University of South Alabama College of Medicine.

This is the first year the program has been offered at Northwestern. Very Special Arts asked Eunice Joffe,

head of training at Very Special Arts Illinois, to find a Midwest venue. "We chose the Rehabilitation Institute because the program in the East was done with hospitals, and we wanted to give it a new look to show that no matter what the setting, the arts are a valuable aid to healing," Joffe said.

Seed money for the Northwestern program was provided by Very Special Arts, with additional funding from Chicago's Department



John McNulty

Anything that normalizes the day for a child and introduces childhood activities helps these kids tremendously. They have fun and benefit from it, too.

INNOVATIVE CARE

of Cultural Affairs. The program was incorporated at Northwestern as one of 16 winter quarter humanities electives. Second-year students chose among courses such as "Civil Liberties and Medicine," "Care of the Dying" and "Early Patient Encounters." Of about 180 second-year students, 50 listed "Arts for Children in Hospitals" as their first choice. Nine women and three men were chosen to participate.

"AT THIS SEASON of medical education, when students are facing exams and national boards and are sick of classes, all of the electives are a breath of fresh air. But this one, combining hospital work with children and the arts, is a whole oxygen tank," said Kathryn Hunter, PhD, co-director of the Ethics and Human Values Program at Northwestern.

The six-week Arts for Children in Hospitals program is facilitated by Joffe and child life expert Jennifer Viets. "We want to teach the students about children, about how hospitals and institutions impact on children and their families, and about how the arts can play a role in the healing process," said Viets. "We also want them to think about how they themselves might use the arts in their work once they become doctors."

On March 14, week three of the program, Latin American musician Nelson Sosa, guitar in hand, joined the students and patients in the fifth-floor playroom. Like a junior high school dance, the event began slowly, with the students clustered on chairs in the center of the room and the patients on the sidelines. Joffe and Viets encouraged the students to get up and move to Sosa's music. By showing their own enthusiasm, the two lively women – tapping rhythm sticks and shaking maracas – prompted the students to help the patients join in.

Gradually, the students approached six or seven children, and together they moved further into the room. Sosa offered drums and tambourines to one and all. Slowly, friendships begun at the previous week's visual art activity were renewed, and the gathering took on a festive air.

"One of the more difficult areas of medical education and training is learning how to work with a sick child," said Charles Sisung, MD, director of RIC's Pediatric and Adolescent Rehabilitation Program. "It can be very anxiety-provoking. Children are very fearful of physicians. The scope of this program is to teach students how to relate to kids, so that they can do more to help with their medical difficulties."

During the hour-long music session, students and patients interacted with one another and with guitarist Sosa. He played and sang songs from all over Latin America, gently encouraging participation. Toward the end of the hour, students worked with the children to create noise-making shakers out of empty syringe cases. They filled the cases with yellow and green dried peas, taped them shut and decorated them with shiny star stickers.

The choice of syringe cases as materials in a program for children and the arts was not accidental.



John McNulty

At this season of medical education, when students are facing exams and national boards and are sick of classes, all of these electives are a breath of fresh air. But this one, combining hospital work with children and the arts, is a whole oxygen tank.

When patient Kristopher Cunningham, 8, saw a case in Viets' hand he let out a shout and cringed in horror until she reassured him that it was empty. "Kids are more scared about needles than anything else, including surgery," Viets said. "We use syringe cases to make toys in an effort to defuse their power."

WITH THE PROGRAM at its halfway mark, Joffe asked the students to describe how they or the children had changed over the program's first three weeks. Most were shy about responding, but eventually Joffe and Viets roused them to discuss their initial apprehension about interacting with extremely ill children. Shavit said he'd been afraid of saying something that would draw further attention to a child's disability.

"If you can get past that and realize you're not going to say something wrong because you're well-meaning and kind, if you proceed with caution and test the waters – as you were all doing today – that seems to work," Joffe said.

In the weeks to come, students will participate in creative dramatics, dance and movement, and an evaluation segment. Ashlesha Patel, 24, is pleased with her choice of this selective. "Art is therapeutic and a good way for these kids to express themselves. I wanted to be part of that."

Dr. Sisung views the arts as another resource for giving his young patients therapy in the form of play. He judges the quality of inpatient rehabilitation programs by the amount of time children are out of their rooms socializing and having fun.

Dr. Sisung added that he would like to see the program continue as a Northwestern selective, noting that it has been well-received by the patients' parents. "Anything that normalizes the day for a child and introduces childhood activities helps these kids tremendously. They have fun and benefit from it, too." ■

Smoking ordinance

(Continued from page 1)

addicted to nicotine is very sad. [The amendment] sends the right signal. Parents will hear about it, and it will help develop a mind-set that smoking is stupid."

According to Dr. Michaelis, about 3,000 U.S. children begin smoking each day. As adults, they develop serious illnesses, such as heart disease, lung cancer and stroke, he noted.

APPROXIMATELY 80 PERCENT of Chicago tobacco vendors sell to minors, said Leonard A. Jason, PhD, a clinical-community psychology professor at DePaul University. Through a study he conducted in 1990 in suburban Woodridge, Dr. Jason learned that tobacco sales to minors could be virtually eliminated through license regulation and a series of compliance checks. Dr. Jason's study sent minors into stores to purchase tobacco products. If the child was sold tobacco products, the merchants were sent a warning letter. According to Dr. Jason, the compliance check system instituted for the study reduced the rate of tobacco sales to minors from 70 percent to almost zero.

Dr. Jason received funding for an additional study to replicate his Woodridge findings in Chicago, said Daniel Schnopp-Wyatt, the study's research coordinator. Through a contractual arrangement, DePaul will conduct compliance checks for the city. The

department was scheduled to begin issuing citations for violations uncovered by the DePaul study on March 28.

Dr. Jason said the study is exciting because it evaluates the cooperative efforts between psychologists and policy-makers. "The study is controlled, documented and systematic. This is the way we should tackle most social problems." The legislative process usually does not allow for proper evaluation of programs before they are implemented, he added.

"The tobacco industry says [using minors] is entrapment, but it is within the confines of the law," said Barbara Silvestri, director of tobacco programs and policy for the American Lung Association of Metropolitan Chicago. The Chicago ordinance and the DePaul study will help Illinois comply with federal legislation that requires states to show that they are reducing tobacco sales to minors. All 50 states have laws restricting tobacco sales to minors, but the measures are not strictly enforced, Silvestri said.

"Illinois law is weak compared to Chicago's," Silvestri continued. Unless Illinois can show that programs such as the DePaul study are in place, the state stands to lose federal block grants for state substance abuse programs, she explained.

"The inconsistency is that we tell kids not to smoke, but vendors will sell to them," Dr. Jason said. "Prevention is not effective with mixed messages." ■

Grass-roots physicians

(Continued from page 1)

ISMS Auxiliary mini-internship program. Dr. Trefzger said he maintained contact with Ewing after the internship, so he felt he had a "foot in the door" for the Washington trip.

Dr. Trefzger said the Washington trip was educational, particularly listening to some of the major players in Congress talk about the bills that might pass and their attitudes toward the various reform packages. He said he was optimistic that physicians will have a greater impact on future legislation. "The Clintons were anxious to keep doctors out of the planning process," he said, adding that legislators who may rewrite or amend the bills seem more open to physician input.

Dr. Trefzger said most physicians in Washington last month agreed that some reform package will likely pass before the November general election. "If it's something both parties could agree on and pass by an overwhelming majority, it's more likely to be the kind of thing that is good for America."

Theodore M. Kanellakes, MD, a Joliet allergist, said he was given adequate time to discuss all the issues during his meeting with a legislative assistant to U.S. Rep. George Sangmeister (D-Joliet). Specifically, Dr. Kanellakes said he talked about the need to enact caps on noneconomic damages in malpractice lawsuits. In areas like Will County, where Dr. Kanellakes practices, insurance premiums are a concern in recruiting obstetricians. "I stated firmly that in Illinois, we have more tort [reforms] in place than what the federal government has proposed," he said.

Dr. Kanellakes added that antitrust reforms are necessary for physicians to deliver the best possible patient care. "In my community, there may be advantages for two hospitals to merge or for physicians to form an independent physician association for better delivery. But our hands are tied in many aspects. Physicians

have to have the ability to organize." Sangmeister serves on the House Judiciary Committee, which will consider legislation containing physician antitrust relief.

Although he said he could not tell how his comments were received, Dr. Kanellakes noted that Sangmeister has been sympathetic to some physician issues. He added that because patients can play an important role in determining a final reform proposal, physicians should try to inform them about key reform issues needed to retain quality care. In addition, doctors should lobby at the local level, he said.

Some lawmakers are confused about the difference between health care and health care delivery, said Ronald J. Simone, MD, a Geneva ophthalmologist who met with U.S. Rep. J. Dennis Hastert (R-Batavia). Dr. Simone said the

United States does not have a health care crisis; instead, there may be problems with health care delivery. "I get perplexed that [legislators] don't seem to grasp this."

James A. Turner, DO, a family physician from Marshall, said he has had a long-standing interest in the "political affairs of medicine." Noting that his grandfather was Clark County Sheriff in the 1930s and his father was a dele-

gate at seven consecutive Democratic National Conventions, Dr. Turner said his knowledge of politics and American history served him well on the Washington trip. Dr. Turner met with U.S. Rep. Glenn Poshard (D-Marion) and a representative for U.S. Sen. Paul Simon (D-Carbondale).

"What bothers me is to hear doctors complain that they don't want to do anything to promote health care issues to legislators," Dr. Turner said. "It's easier to stand back and complain." He recommended that physicians find some way to become involved in the political process, such as voting or calling legislators. The important thing is to get involved, he said. ■

In my community, there may be advantages for two hospitals to merge or for physicians to form an independent physician association for better delivery. But our hands are tied in many aspects.

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IMPAC Annual Meeting and election scheduled

The Annual Meeting of the Illinois State Medical Society Political Action Committee will take place Friday, April 22, at the Oak Brook Hills Hotel. The meeting, open to all IMPAC members, will convene in Court G/H immediately after the ISMS House of Delegates morning session.

Business will include election of IMPAC Council members. Nominees for appointment or reappointment to

the council are Edward J. Fesco, MD, LaSalle; Jere E. Freidheim, MD, Chicago; Raymond E. Hoffmann, MD, Rockford; Harold L. Jensen, MD, Harvey; Janis M. Orlowski, MD, Chicago; Sandra F. Olson, MD, Chicago; Edward F. Ragsdale, MD, Alton; Alan M. Roman, MD, Flossmoor; John F. Schneider, MD, Chicago; M. LeRoy Sprang, MD, Evanston; and Pam Taylor, Danville. ■

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Election analysis

(Continued from page 1)

bills to remove disincentives for primary care physicians to participate in the Medicaid program.

With control of the House and Senate hanging in the balance, observers say candidates' positions on tort reform, including caps on noneconomic damages, are of vital concern to Illinois physicians.

Edgar, an outspoken proponent of tort reform, has expressed his belief that the current legal system produces too many lawsuits with large awards, causing health care costs to soar. He supports reforming medical malpractice laws and product liability laws during this session of the General Assembly.

Two bills important to physicians have already been introduced in Springfield and are in the Senate Rules Committee: S.B. 1824, which limits awards for noneconomic damages in tort suits, including malpractice cases, to \$250,000; and S.B. 1508, which also limits noneconomic loss recovery to \$250,000 and additionally requires written instructions about the cap to be given to the jury.

These bills are not expected to pass this year. Senate President Pate Philip (R-Elmhurst) has tied Republican support for riverboat gambling to Democratic support for tort reform and changes in workers' compensation. Last year, House Speaker Michael Madigan (D-Chicago) opposed tort reform.

In key state Senate races, 20th District Republican incumbent Beverly Fawell (R-Wheaton) defeated opponents Mike Formento, who had trial lawyer support, and Timothy Whelan. Fawell advocates a \$250,000 cap on noneconomic damages, Medicaid reforms, a health care system based on a public-private partnership financed by a combination of government funding and employer-paid benefits, and the use of pension plans, IRAs and 401(k)s for tax-free insurance purchases.

In the 29th District – which analysts say periodically swings between Republican and Democrat – Republican Kathleen Parker defeated Robert Acri and Thomas Eilers. Parker supports a \$250,000 cap on noneconomic damages and has said that tort reform is the key to health care reform in Illinois, according to election observers. She has also said that quality of care should be of primary concern in any health care reform measure passed. Analysts also note that the race in this generally Republican district will play a key role in determining which party controls the Senate. Parker will face a tough opponent in Democratic incumbent Sen. Grace Mary Stern (D-Highland Park), who opposes caps and has come out in favor of the Clinton health care plan.

In the 41st District, Republican Sen. Kirk Dillard (R-Westmont) – the governor's former chief of staff and a first-time political candidate – narrowly defeated Pat Trowbridge, who was supported by the trial lawyers. Dillard favors a \$250,000 cap on noneconomic damages and Medicaid reform.

said that Medicaid should be protected and that reform in Illinois must address prevention, quality care, access and financial protection from health care expenses. She also said that a flat cap of \$250,000 would not be fair in all instances.

In the 34th District, Democratic incumbent Rep. Nancy Kaszak (D-Chicago) won easily over opponents Thomas Foley and John Lee Bingham, both of whom support caps. Kaszak, who observers say received significant support from the trial lawyers, has voted against tort reform in the past.

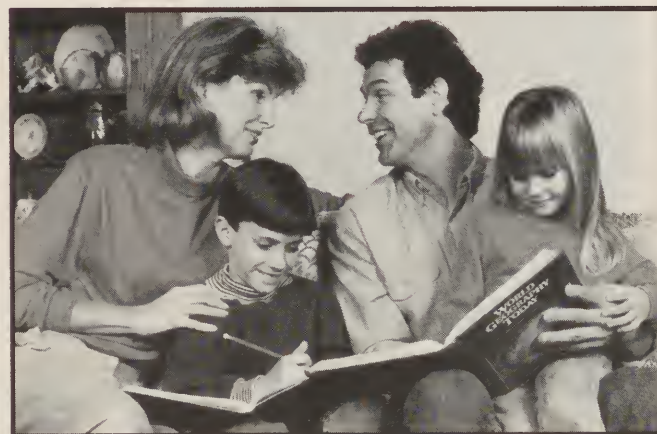
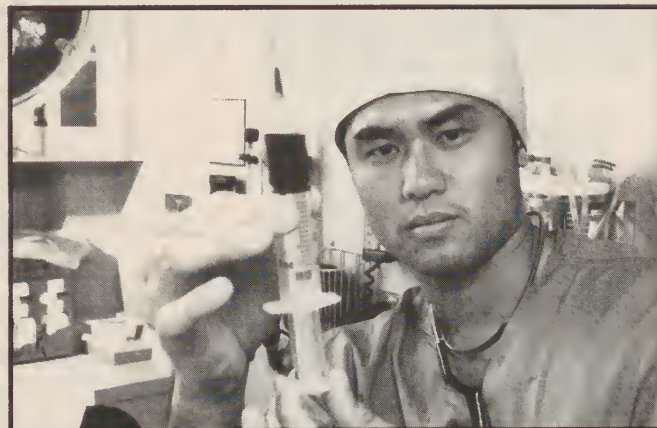
The 56th District race pitted Republi-

can incumbent Rep. Carolyn Krause (R-Mt. Prospect) against pro-gun candidate William Klicka. Krause, who supports caps and tort reform and patients' rights to select their own physicians, defeated the challenger.

In the 59th District – which analysts label a swing district in the battle to control the House – Republican and caps-supporter Mary Beattie lost to Tom Lachner. Observers called the race a tough primary battle. Lachner will face Democrat Christopher Wakefield this fall.

In other House races, Republican incumbent Rep. Ann Hughes (R-

McHenry) defeated Steven Verr and Virginia Pesche in the 63rd District and will face Democrat Lee A. Carpenter in November. Rep. Judy Biggert (R-Westmont), a co-sponsor of a tort reform bill and the Republican spokesperson on the House Judiciary I Committee, emerged victorious in the 81st District race over James McCarthy. And in the 100th District, Republican Gwen Klingler, who is a physician's spouse and favors caps, defeated James Dunham. Analysts predict she will face a tough battle in November against Democratic incumbent Michael Curran. ■



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TURNING TO KEY House races, in the 12th District, Democrat Sara Feigenholtz, the daughter of a physician, won over Democratic incumbent Rep. Ellis Levin (D-Chicago). Levin is a long-time opponent of caps and tort reform. Feigenholtz

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First lady lauds
 proposal for
 women's health
 care

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ISMS President Arthur R. Traugott, MD (left), testifies before a Senate committee, explaining why legislators should vote against a bill that expands optometrists' scope of practice.

Optometrist bill moves in Senate

LEGISLATION: Physicians oppose a measure that allows optometrists to diagnose and treat eye disease. By Anna Chapman

[SPRINGFIELD] A bill expanding optometrists' scope of practice moved one step forward in the Illinois Senate March 30, despite physicians' attempts to block it. The Senate Executive Committee voted 9-3 to move S.B. 1207 to the full Senate; two committee members voted present. Sponsored by Sen. Frank Watson (R-Carlyle), the bill permits optometrists to diagnose and treat eye disease — functions that only physicians may currently carry out under Illinois law.

In testimony before the committee, ISMS President Arthur R. Traugott, MD, called the bill "unnecessary and ineffective," noting that there is not a short-

Call to action

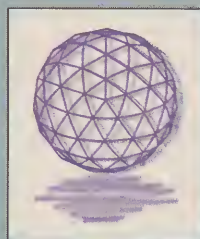
Call your state lawmakers and tell them to vote no on S.B. 1207. According to ophthalmologists and physicians throughout Illinois, the bill poses potentially serious health risks to patients. Call the Capitol at (217) 782-2000 and ask for your state senator. Let him or her know your views.

age of ophthalmologists in Illinois, so such legislation is not warranted. Dr. Traugott explained that the bill's provi-

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AMA introduces anti-tobacco campaign

HOW TO QUIT: A new smoking-cessation program features physician involvement. By Tamara Strom

[CHICAGO] Through its National Wellness Stop-Smoking Campaign, the AMA launched a three-part anti-tobacco strategy March 30 aimed at helping the approximately 45 million U.S. smokers kick the habit.

"For decades, the tobacco industry has bombarded the public with marketing campaigns to lure people into smoking," said Randolph Smoak, MD, an AMA trustee. "The time has come to stop whining about smoking and start acting aggressively to protect our children and ourselves from the lies and misinformation of the tobacco industry. We are offering the 45 million Americans

who smoke proven methods to overcome their deadly habit while ensuring nonsmokers the right to clean air."

The campaign complements the AMA's existing public health programs and underscores physicians' goal of "putting patients first," added P. John Seward, MD, an AMA trustee from Rockford. "The program also fits in with our objective to achieve a smoke-free society by the year 2000. Doctors have always been involved in helping patients quit smoking, but we're dealing with a difficult addiction here. This program gives physicians the tools they need to help patients."

(Continued on page 19)

ISMS implements new hot line, legal services

ACTION: New Society programs are designed to help members deal with the complexity of the medical marketplace. By Tamara Strom

[CHICAGO] In response to physician requests, ISMS is creating new member services to help doctors deal with the changing health care delivery environment. The services, which resulted from the Society's Medical Leadership Initiative, will be in effect April 25.

"In these challenging times, we must work proactively to adjust to the complexity of the marketplace," said ISMS President Arthur R. Traugott, MD. "With the reform debate progressing and businesses forcing cost-driven changes onto health care delivery, physicians can no

longer afford to sit back and watch the transformation. We must become active players in the market so that we can preserve quality care for our patients. Through the Medical Leadership Initiative and its component programs, ISMS members can take charge and make the necessary changes in their practices to ensure that they are prepared for the results of health care reform and the increased presence of managed care entities."

To help members obtain answers to their questions about

(Continued on page 19)

Blues' studies show hospitals and physicians can improve rates for cesarean sections

MANAGED CARE: The Blues shares methods culled from its HMO participants. By Anna Chapman

[CHICAGO] Culminating years of review of its managed care programs, Blue Cross and Blue Shield of Illinois presented evidence during a March 11 roundtable that hospitals can lower their cesarean section rates.

Medical directors from Blues managed care organizations, hospital department heads and members of hospital obstetrics depart-

ments attended the conference, which was held to disseminate information the Blues collected regarding c-sections, said Burton VanderLaan, MD, Blues managed care medical director. "The hope would be for each of us to return to our respective institutions and practices and to put into place some of these

(Continued on page 16)



First lady Hillary Rodham Clinton and Chicago Ob/Gyn Allan Charles, MD, discuss ways to improve the health of women in cities.

First lady lauds proposal for women's health care

REFORM: Chicago health officials outline remedies for health care problems of urban American women. By Kathleen Furore

[CHICAGO] Chicago physicians and health officials presented a summary of the "urban women's health agenda" to first lady Hillary Rodham Clinton, U.S. Sen. Carol Moseley-Braun (D-Ill.) and U.S. Rep. Dan Rostenkowski (D-Chicago) during an April 4 meeting at the Infant Welfare Society. The agenda, which calls for sweeping changes in the U.S. health care system, was prepared by a 40-member task force on women's health convened by Chicago Mayor Richard Daley. Serving on the task force were three Chicago-area Ob/Gyns — Allan Charles, MD; Linda Holt, MD; and Julian Ullman, MD.

The agenda is a step forward in addressing problems faced by urban women who try to access comprehensive, affordable health care, said Chicago health commissioner Sister Sheila Lyne, RSM, who serves as co-chairman of the task force. "The agenda is significant for a number of reasons. At a policy level, we expect it to have an impact on the national health reform deliberations. On a local level, we expect the agenda's 'block by block' approach to be adopted in model programs across the metropolitan area, as health care providers and others establish linkages, work to end duplication of efforts, fill in service gaps and ultimately improve the health status of women as a group and as individuals."

Expressing her appreciation to the task force for what she called a "remarkable document," Clinton said she was impressed that the agenda recognized the need for comprehensive health care reform, the "absolute promise of health care coverage and a comprehensive set of benefits that includes preventive and primary care" for every American.

The task force's agenda includes programs and legislative solutions to alleviate access barriers for urban women. The barriers addressed include the threat of domestic violence and homicide; a dearth of basic preventive services such as Pap smears, breast and pelvic exams, and physicals; a lack of prenatal care; the unavailability of contraceptive options; insufficient information about osteoporosis and heart disease; and a

high incidence of teen pregnancies and abortions.

The impact of those barriers on women and society was explained by Dr. Charles, head of obstetrics and gynecology at Chicago's Michael Reese Hospital and Medical Center. "I have seen the tragic results of teen pregnancies, drug abuse and the lack of prenatal care and parenting skills. Lack of prenatal care leads to infants who need intensive and very expensive care. And they're ultimately thrown into an environment unable to cope with their special needs. The burden to society is immense."

To remedy such problems, the task force recommended the following:

- Mandating statewide access to univer-

sal health coverage and an affordable, basic health benefit package for all Illinois residents by 1995;

- Levying a two-cent tobacco tax on every pack of cigarettes to fund breast cancer research and early detection programs;
- Banning all handguns and assault weapons;
- Proposing clear identification and documentation requirements in hospital emergency rooms for incidents of domestic violence, and mandating that resources such as social workers, counselors and information on temporary housing be available in ERs;
- Developing more comprehensive assessments of young mothers to determine their ability to care for themselves and their infants; and
- Requiring third-party group health insurance carriers licensed in Illinois to develop and offer an affordable, comprehensive health insurance plan for children ages 4 to 18. The coverage, to be offered through schools, would include a waiver of pre-existing conditions and provide wellness exams, routine immunizations, eye and dental care and accident and illness coverage.

The agenda also stresses the importance of improving women's self-esteem, increasing the number of women in health care careers and fostering cooperation between Chicago health care institutions and health care providers, including social service agencies, trade associations, women's organizations, educators, government leaders and consumers.

"There are several important lessons from what you have done here in Chicago," Clinton told the task force representatives. "You've recognized that so many of our health, economic and social problems connect one to the other [and that] we can no longer expect Band-Aid solutions to help resolve the health care crisis."

Gang violence halts immunization program

[CHICAGO] An immunization update program organized by physicians at the University of Chicago Hospitals was temporarily suspended in late March by gang warfare at the Robert Taylor Homes on Chicago's South Side. Since January, emergency medical technicians trained by physicians at the U of C's Wyler Children's Hospital had conducted door-to-door evaluations of the immunization records of preschool children. The goal of the Pediatric Immunization Program is to raise the "frighteningly low" vaccination rates among Chicago children, said program co-director Cai Glushak, MD, a U of C emergency physician and medical director of the First Aid Care Team, which provides emergency care to injured Robert Taylor Homes residents before paramedics arrive.

The immunization program was prompted by outbreaks of pertussis recently and a measles epidemic in Chicago several years ago, which occurred because young children had not been properly immunized, Dr. Glushak said. Physicians at Wyler Children's Hospital trained two FACT members to conduct the immunization program, which includes collecting immunization records from parents and clinics, reviewing immunization records and determining which, if any, immunizations have been missed, Dr. Glushak said. The EMTs also educate parents about recommended immunizations, he added.

Once the EMTs determine whether children's immunizations are up-to-date, they follow up with parents to ensure the children receive additional preventive care from a physician.

The EMTs do not actually inoculate children, because they are not trained to handle drugs, and the physicians who started the program did not want to provide vaccinations as a "quick fix," Dr. Glushak said.

Currently, the Wyler physicians are analyzing the data the EMTs have gathered regarding children's immunization rates, Dr. Glushak said. The data will be used to determine whether the program increases immunization rates sufficiently to support using the program as a model for preventive practices in other poor communities. The U.S. Centers for Disease Control and Prevention has also expressed interest in the program as a possible national model, he said.

But for now, the program is on hold because gunfire is forcing the EMTs to remain indoors. "For a couple of days, they couldn't leave their offices," said Sherry McGinnis, a U of C spokesperson.

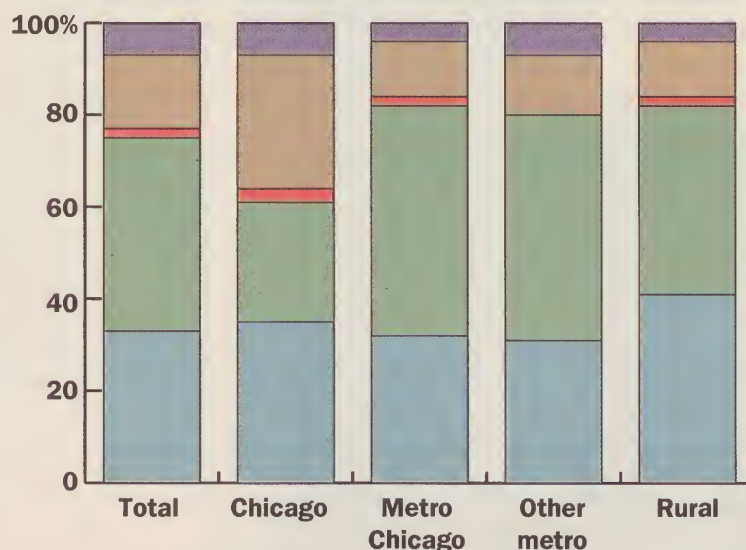
Dr. Glushak said he expects the violence to ease shortly and the program to be resumed.

PHYSICIAN FACTS

Type of practice of Illinois physicians

■ HMO ■ Other/no answer ■ Hospital based
■ Solo ■ Partnership/group

Practice type by region



Source: Illinois State Medical Society, Illinois physician census, November 1993

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Chicago physician seeking volunteers for Croatia trip

[CHICAGO] Michael E. Schafer, MD, an esthetic and reconstructive surgeon at Chicago's Rush-Presbyterian-St. Luke's Medical Center, traveled to Croatia last winter to determine how he could help people – especially children – injured in the war. Now in the early stages of planning a return trip to volunteer at a children's hospital in Zagreb, Dr. Schafer is seeking physicians to accompany him to the war-ravaged country. Specific dates and travel arrangements have not yet been made, he said.

"They need physicians from a variety of specialties – pediatric surgeons, urologists, neurosurgeons," Dr. Schafer explained. "There's also a need for expendable supplies like sutures, medications and bandages. They've been treating patients without pay or reimbursement since the war began, and they've exhausted their supplies."

In planning the trip, Dr. Schafer said he has been corresponding with the director and chief of surgery at the Institute for Mother and Child Health in Zagreb. The hospital recently established the Committee for the Child in War, which was created to provide complete medical care to children; gather and distribute medications, food and clothes; and educate medical experts about the special needs and problems of children living in war conditions.

Dr. Schafer's ties to Croatia date to 1963, when he vacationed there between college and medical school. He took another trip to then-Yugoslavia in 1971. He said he has always been struck by the country's beauty and its people, and he has been troubled by the war since the aggression began in 1991.

"I had been following the war in Yugoslavia with a sense of frustration, awe and disbelief. I was struck by the inability of the rest of the world to do anything," said Dr. Schafer, who has previously traveled on group medical missions to the Philippines, Thailand and Honduras. "Then I saw 'Schindler's List' and saw how one man could make a difference. That's when I decided to just go by myself to Croatia, even though I didn't have any contacts or appointments and had no idea where I was going. I decided to go on Monday, bought my plane tickets and left on Wednesday."

On his flight between Zurich and Zagreb, Dr. Schafer met a man who was related to Croatia's minister of health and who knew the Croatian president's special adviser for humanitarian affairs. Thanks to that chance encounter, Dr. Schafer was able to schedule an appointment with the adviser, who introduced him to the chief of surgery at the children's hospital. During the meeting, Dr. Schafer explained his desire to help Croatian children and discussed ways he might accomplish that goal.

"We decided that I would make contacts with organizations [in the United States], form teams [and] then go back to Croatia with help and supplies," Dr. Schafer said. "That's where I am now. I'm beginning my inquiries here and working with him on a list of people and things he needs."

Physicians interested in traveling to Croatia or in donating supplies may contact Dr. Schafer at (312) 563-4000. ■

Public health budget includes computer network

[SPRINGFIELD] "To provide care and services to some of our neediest citizens," Gov. Jim Edgar last month proposed a \$454-million 1995 fiscal year budget for the Illinois Department of Public Health. The proposal includes funding for a computer network to streamline the enrollment of needy women and children in various health services.

Called Project Cornerstone, the information network will create one entry point into such health services as the Women, Infants and Children program,

childhood immunization programs and Healthy Moms/Healthy Kids. "This will increase efficiency, remove obstacles to participation in state programs and enhance the quality of service we provide," Edgar said.

IDPH expects 80 percent of its recipients to be included in the Project Cornerstone data base by the end of fiscal 1995. A total of \$3.7 million, including \$1.75 million in new state funds, has been earmarked for the project.

Also included in Edgar's proposed budget are the following:

- Expansion of AIDS education, prevention and medical care efforts. This encompasses a 3.3-percent increase in

spending – effective April 1, 1995 – for local health departments, HIV/AIDS services and sexual assault prevention;

- Funding of \$6.6 million for the Healthy Start program, which targets six Chicago areas with high infant mortality rates;

- A 10-percent increase in WIC program spending, bringing total funding to \$200 million. This will allow IDPH to increase its caseload by 24,000 participants, to a total of 250,000 per month; and

- Funds of \$308,000 for health departments expected to become state-certified in Bureau, Clark, Crawford, Jefferson and Knox counties. The money will also help develop three new health departments. ■

Blue Cross Blue Shield



REPORT FOR Illinois Physicians

NEW RULES FOR PRE-CERTIFICATION AND CLAIMS PROCESSING FOR BOARD OF EDUCATION EMPLOYEES

THE FOLLOWING RULES APPLY ONLY TO ACTIVE BOARD OF EDUCATION EMPLOYEES - NEW GROUP NUMBER: P12500 (ACTIVE EMPLOYEES ONLY)

MENTAL HEALTH / SUBSTANCE ABUSE SERVICES

Effective for dates of service on and after March 1, 1994, Blue Cross and Blue Shield of Illinois (BCBSI) will no longer perform pre-certification or claim processing for mental health and substance abuse services. **Pre-certification and claims processing will be handled by Illinois Biodyne.**

Please call (800) 242-8244 for pre-certification and send your claims to Illinois Biodyne, P.O. Box 319032, Chicago, Illinois 60631-9032.

MEDICAL / SURGICAL SERVICES

Effective for dates of services on and after March 1, 1994, BCBSI will no longer perform pre-certification for inpatient admissions or for certain outpatient services for which pre-certification is required. These services are listed below: **Pre-certification of these services will be handled by Healthmarc at (800) 338-1126.**

Outpatient Services Requiring Pre-Certification

- Arthroscopy of the Knee/Shoulder
- Breast Biopsy
- Bunionectomy
- Cataract Extraction
- Chemotherapy
- Hammertoe Repair
- Herniorrhaphy [all]
- Laparoscopy
- Magnetic Resonance Imaging (MRI) Exams [all]
- Myelogram
- Myringotomy with/without Tubes
- Positron Emission Tomography (PET) Scans
- Radiation Therapy
- Septoplasty
- Tonsillectomy with/without Adenoidectomy

However, for claims processing, please continue to follow your normal Blue Cross filing procedures. If you have any further questions, please call our Provider Assistance Unit at (312) 938-7340.

ISMS town meetings spotlight reform

To promote discussion of the necessary components of health care reform, ISMS sponsored a series of four town hall meetings around the state earlier this year. The meetings – held in Carterville, Chicago, Rockford and Springfield – featured local physicians, community leaders, business representatives and state and federal lawmakers. Question-and-answer sessions during each meeting enabled individuals to express their views on reform and learn more about the process.



Mychael Wozniak



Mychael Wozniak

Audience members (above), including ISMS 6th District trustee Robert F. Hamilton, MD (standing, left), line up to ask questions during the Feb. 16 meeting in Carterville. Alec Hood, MD (far left), a McLeansboro general surgeon, represents the local physician community on the panel.



Ron Ackerman

Attendees (above) sign in at the Feb. 3 Springfield meeting and pick up copies of an ISMS brochure outlining the questions patients most commonly ask about reform and possible answers. ISMS 5th District trustee Jane Jackman, MD (left), details physicians' concerns about maintaining high-quality health care. A member of the audience (below) puts a question to the panel during the well-attended meeting.



Mike Woolridge

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ISMS President-elect Alan M. Roman, MD (below), tells participants at the Jan. 26 town meeting in Chicago that the United States must enact a reform plan that puts patients first. Several local residents (right) wait their turn to share their ideas for containing costs.



M. Candee Studios



M. Candee Studios

During the Feb. 10 town meeting in Rockford, ISMS 12th District trustee William Kobler, MD (left), explains why government-run health care would jeopardize quality care and put patients at risk.



John McGinty

Mike Woolridge

HMOs and PPOs make their mark on several states

Managed care is on the rise in Maryland, Massachusetts and Minnesota. By Anna Chapman

As hospitals, physician groups and insurance companies jockey for position in the changing medical marketplace, managed care activity is increasing in individual states. *Illinois Medicine* continues its series on managed care by examining that development in Maryland, Massachusetts and Minnesota.

Maryland

Maryland is experiencing "tremendous positioning and movement" toward managed care, according to Benjamin

Avrunin, MD, chairman of the managed care committee of the Medical and Surgical Faculty of Maryland, the state's medical society. HMO penetration in Maryland reached 27.1 percent in

1992, according to the *Marion Merrell Dow Managed Care Digest*. The state's largest managed care players are Kaiser Permanente HMO, Humana Health Plans and the MD IPA, started 10 years ago by physicians in response to the infiltration of large HMOs, Dr. Avrunin said. Currently, MD IPA serves between 800,000 and 900,000 patients, he added.

Many Maryland physicians participate in IPAs and PPOs, Dr. Avrunin said. According to Marion Merrell Dow, there were 58 PPOs in the state in 1992.

Networks are also being rapidly formed in Maryland, Dr. Avrunin noted. Hospitals are buying physicians' practices, and physicians are deciding which groups to join, he said. The medical society is planning a network and compiling data from a managed care survey of its members. The survey, conducted earlier this year, asked physicians to rate their experiences with managed care programs in such areas as diagnostic testing, professional services, authorization mechanisms and administrative relationships.

The medical society's managed care committee helps physicians with managed care issues and problems, Dr. Avrunin said. The committee investigates physician complaints against managed care companies and tries to resolve disputes by contacting the companies involved. Those challenges sometimes arise from doctors' failure to follow procedural flow charts designed by the program for particular conditions, he said. Such flow charts might require physicians to follow specific precertification procedures. The committee also reviews complaints against companies for questionable payment practices.

The state is also taking a more active role in health care delivery, Dr. Avrunin said. A new Maryland law requires insurance companies to use community rating and limit pre-existing condition exclusions in their policies, he noted. Eventually, the state will also set guidelines for physicians' fees, he added. A

seven-member commission to regulate fees and scrutinize office laboratory charges is already being formed. "No one knows all the implications yet," he said, but noted that physicians, especially those in primary care, are concerned.

"The bottom line is managed care is

here to stay," he added. "People are adjusting."

Massachusetts

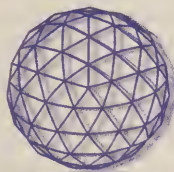
With 34.8 percent of the state's population belonging to one of 20 HMOs, Massachusetts claims the highest HMO

penetration in the country, having recently surpassed California, according to the Massachusetts Medical Society. Four out of five physicians participate in at least one managed care plan in the state. PPOs are not a strong force in Massachusetts, although a statute allowing the formation of PPOs was established in 1988, said Yael Miller, MMS managed care affairs coordinator. Five leading managed care health plans corner 75 percent of the health care market share in the state, she noted.

Massachusetts' Medicaid population is covered under a managed care program with two enrollment tracks, Miller said.

(Continued on page 15)

MANAGED CARE



to the *Marion Merrell Dow Managed Care Digest*. The state's largest managed care players are Kaiser Permanente HMO, Humana Health Plans and the MD IPA, started 10 years ago by physicians in response to the infiltration of large HMOs, Dr. Avrunin said. Currently, MD IPA serves between 800,000 and 900,000 patients, he added.

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Contraindications: Severe LV dysfunction (see Warnings)—hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.
Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.
Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

Benefits of membership

Every now and then, you hear the question, What am I getting for my dues dollars? It's an understandable response to these uncertain times. But when you make that assessment, don't overlook the vital benefits you're receiving.

With membership in ISMS, your county medical society and the AMA, you're getting strength in numbers. There has never been a more critical time for physicians to be involved in organized medicine. The health care environment is changing quickly and dramatically, as some businesses seek one-stop shopping for their employees. And even though the reform bills pending in Congress may not pass intact, reform is coming at the federal and state levels. As an individual physician, you can have impact by contacting your legislators, but think of the greater impact of hundreds and even thousands of physicians working together.

ISMS has already done a great deal to help you prepare for reform, and more support is coming. The Society has been a proactive leader in advocating for patients and helping define the components of reform. An analysis of the Clinton plan was sent to you soon after the reform proposal was announced, and *Illinois Medicine* has helped keep you up-to-date on related issues. The Society, along with county medical societies, held town meetings across the state to allow patients, providers, legislators and businesspeople to exchange views. In addition, you've received a kit to help you

discuss reform with your patients.

Through the Medical Leadership Initiative, ISMS staff and members have traveled throughout the state to elicit information about your specific market and needs. Your feedback resulted in the new Legal Services Referral Program and hot line detailed in this issue. The referral program will enable you to find an attorney who is knowledgeable about health care and who has been screened and recruited by ISMS. By calling the hot line, you can get quick responses to your questions about managed care.

The Society has been busy at the federal level, too. Grass-roots ISMS members attended a recent AMA summit meeting to talk to federal legislators about physicians' concerns regarding reform. And your elected leaders regularly meet with the Illinois congressional delegation as part of the Washington Presence program.

If you're an ISMIE policyholder, you're receiving malpractice coverage from a premier insurer. Surveys are conducted regularly to determine policyholders' satisfaction and identify areas for improvement. You also have access to such benefits as risk management seminars, a toll-free 800 number, defendant reimbursement coverage and aggressive litigation preparation.

Through membership in ISMS, you tap into resources that would otherwise be unavailable to you. Don't take them for granted, but do take advantage of them.

PRESIDENT'S LETTER

What we've accomplished together

By Arthur R. Traugott, MD



*The slogan
'Evolve or
become extinct'
has never been
more apt.*

This is my last letter, as my term as your president will soon end. My travels throughout our state have been highlighted by getting to meet many of you personally. You have shared your ideas about reform and legislative issues, as well as your concerns about the daily practice of medicine, at county medical society, ISMS and AMA meetings.

I'd like to recap a few of the highlights of the past year. Soon after taking office last April, I was called to testify in Springfield on the need for a \$250,000 cap on noneconomic damages in tort cases, including malpractice awards. I explained to the House Judiciary I Committee that ISMS wants fairness and justice and that a cap would help juries do their job effectively and fairly.

Although parliamentary maneuvers prevented the bill from progressing, it had moved from the Senate to the House. Our position was heard by legislators and will continue to be heard as your new leaders continue the fight for caps.

Last year, the Senate passed a resolution calling for a study of economic-based credentialing decisions. The issue was mandated by last year's House of Delegates.

Last month, ISMS and the Illinois Hospital Association reached agreement on model state legislation to ensure due process and a fair hearing procedure for all medical staff members whose privileges are threatened by economic decisions. The measure also establishes standard procedures for initial medical staff applicants. The legislation has been introduced in the current legislative session, with an effective date of Jan. 1, 1995.

In November 1993, Blue Cross and Blue Shield of Illinois announced its imposition of practice guidelines in several specialty areas in one of its managed care programs. ISMS responded immediately because of the prospect that those guidelines could become clinical dictates threatening the quality of patient care. We request-

ed a meeting with the Blues leadership.

We reached a consensus that broad-based educational efforts and discussions within the state's medical community are essential to development and use of such guidelines. In addition, ISMS was given a position on the Blues' Quality Standards and Studies Committee, and the Blues will have an opportunity to participate on an ISMS committee.

Society activities required me to travel outside the state as well. Through ISMS' Washington Presence program, I made trips to the nation's Capitol to inform legislators of our position on health care reform issues. Specifically, ISMS has made a strong case for the need for antitrust reform and tort reform, and has championed maintaining high-quality patient care.

The changing health care marketplace has been the overwhelming concern this past year. Along with Society representatives, I have attended hospital medical staff meetings and county medical society meetings to learn what changes are occurring throughout the state and what services and programs are needed to help our members cope with these changes. More than 70 such visits have now been completed, and as a result of your input, a new legal services referral network and a hot line have been initiated. In addition, the Society has commissioned a feasibility study to evaluate possible development of an HMO, an IPA or some other managed care option.

Thank you for the opportunity to serve as your president. I have seen firsthand how your medical society and leadership are working for you. The challenges we face are tremendous. The slogan "Evolve or become extinct" has never been more apt. With your continued commitment, support and encouragement, your newly elected leaders will continue along this course. Please work with them to keep ISMS evolving, so that we can continue to provide our patients with the finest medical care.



"I've been a doctor for 45 years. I figure in about 22 more years I'll get all my paperwork done."

GUEST EDITORIAL

Legalizing illicit drugs sends wrong message

By Tom Hedrick

This article is reprinted with the author's permission from the February 1994 issue of Michigan Medicine.

Any policy discussion that includes consideration of legalizing drugs reflects either a complete misunderstanding or ignorance of the key facts that affect trial and use of these substances. Legalization sends the societal message of public approval, eroding the anti-drug attitudes of our youth and encouraging them to try and use illegal drugs. What we need is the reverse — establishing the unequivocal message that our public behavior standard and social norm are "no use," to be continuously reinforced through the attitudes of harm and risk and social disapproval, which are proven inhibitors to our youth's trying and using these substances.

First, it is critical to recognize that drug abuse is, at its core, the result of the demand we as individuals and society create for these drugs. Prior to drug use becoming the disease of addiction, all drug trial and use are the result of decisions and choices we make to use or not use. The primary determinants in these decisions are the attitudes of 1) perceived harm and risk and 2) social disapproval. This is true across ethnicity, demography and geography. All progress in reducing drug use and, ultimately, addiction, is the result of increasing anti-drug attitudes to change the behavior.

The message of legalization is precisely antithetical to everything we've learned about preventing the demand for illegal drugs. The epidemic of illegal drug use over the past three decades was the

result of these substances, their use and their users becoming "normalized" — perceived as benign and an accepted part of normal social behavior. Normalization has led to nearly 80 million Americans' having tried illegal drugs. Because we did not understand the impairment and harm that result from using illegal drugs, we passively and actively moved away from the behavior standard and social norm of no use.

The reverse process of "denormalization," which began with the death of Len Bias in 1986, has resulted in a decline of more than 50 percent in the number of Americans using illicit drugs. This fact is not well-known and probably is responsible for much of the sense of hopelessness and helplessness that often surrounds the issue of drug abuse. As a nation, we began to recognize the harmfulness of drug use, and we began to re-establish the social norm of no use. All the declines in trial and nonaddicted use of illicit drugs are directly correlated with the increase in the attitudes of perceived harm and risk and social disapproval.

Importantly, however, most recent trends among young teens indicate an erosion in their key anti-drug attitudes of risk and disapproval, resulting in higher usage rates of marijuana, LSD, cocaine and inhalants. Further confusion in the behavior standard and social norm of no use, especially consideration of legalizing (read normalizing) illicit drugs, will surely accelerate this disturbing trend and put us back into the drug epidemic of the 1970s and early 1980s.

Hedrick is president of the Partnership for a Drug Free America.

GUEST EDITORIAL

Appropriate therapy for health care delivery

By James Ahstrom Jr., MD

To ensure that health care reform actually addresses the system's ills, society would do well to follow the example physicians set in treating their patients. Before treating a patient's clinical problem, physicians take a detailed medical history, which revolves around the patient's chief complaints, to gather as many pertinent facts as possible. Then we perform a thorough physical examination and order further tests as needed. These can be simple procedures or complex invasive tests, depending on how much additional information is needed to assess a patient's problem. Once all this information is compiled, we formulate and carry out a treatment plan.

Similar principles should be applied to the process of improving our health care delivery system. First, we should focus on what is actually wrong with the system. Too many words are being wasted on treatment without an exact diagnosis.

Allegedly, the chief complaint is high cost. But what is the proper cost for a system that delivers the quality of care received by most Americans? That question has not yet been answered.

Cost can be determined by listing such expenses as hospital charges, medicine, transportation, tests, equipment, insurance premiums and fees. Hospitalization, which accounts for 40 percent of total U.S. health expenditures, represents the system's greatest cost. Of course, hospitalization includes a gamut of additional services and care, such as drugs, diagnostic tests, counseling, team evaluations, therapy treatments and administrative functions.

Those services are expensive, and they could be used more judiciously. In addition, hospital bills sometimes contain large errors, usually in favor of the hospital. By evaluating which services are ordered for hospitalized patients and scrutinizing hospital bills, hospital charges can be lowered, significantly reducing overall health care costs.

The high price of pharmaceuticals has also been discussed. But since reducing drug company profits by 50 percent would decrease total health care expenditures by less than 1 percent, the role of drug prices has been exaggerated.

Tort reform, namely a \$250,000 cap on noneconomic damage awards in

medical malpractice lawsuits, is a prescription physicians advocate to reduce health care costs. The threat of malpractice suits forces doctors to practice defensive medicine, ordering unnecessary tests and procedures that drive up costs. Liability reform will help restore stability to the tort system by eliminating skyrocketing jury awards and will enable doctors to resume the practice of medicine based on their judgment, not the fear of being sued.

The nation's secondary complaint is that some Americans lack health insurance. However, this group comprises only 15 percent of our population; that means 85 percent do have insurance. Therefore, we need a 15-percent fix, not a 100-percent fix.

It is more prudent to focus on the 15 percent and alleviate their predicament. The current administration has advocated employer mandates — requiring

employers to buy health insurance for their workers — to cure the problem of the uninsured. But what happens when individuals lose their jobs? This eventuality, as well as solutions aimed at providing coverage for those who are currently unemployed, has not been addressed in-depth. That is

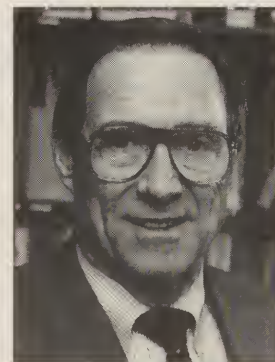
why employer mandates ring hollow.

The next logical step, then, is for individuals to purchase their own insurance. Financial aid may be necessary in many cases. To pay for their insurance, people could receive help through favorable tax treatments for premiums, health care IRAs, vouchers or even outright government assistance through aid or loans. And because only 15 percent of the population need insurance — and possible assistance to pay for it — it seems obvious that we don't need to overturn, revolutionize or destroy the entire system. We just need to provide coverage for

those Americans currently without insurance and for those changing jobs.

To accomplish the major goals of health system reform — diminishing costs and making sure that the uninsured receive some type of health insurance coverage — we do not have to destroy the current system and establish a new structure of unknown quality and stability. Instead, we should concentrate on the patient's main complaints and find ways to correct them.

We should focus on what is actually wrong with the system. Too many words are being wasted on treatment without an exact diagnosis.



Dr. Ahstrom is an orthopedic surgeon in Downers Grove and Oak Park.

New law provides language assistance guidelines for facilities

TRANSLATORS: Act offers help to non-English-speaking patients.
By Kathleen Furore

[CHICAGO] The Language Assistance Services Act, which became effective Jan. 1, offers guidelines that health facilities may follow to ensure access to health care information and services for Illinois residents who speak little or no English or who are deaf.

According to the legislation's sponsor, Sen. Jesus Garcia (D-Chicago), the law has the potential to improve health care for patients who have previously experienced problems in communicating with doctors, nurses and other providers because of the patients' inability to speak

or understand English.

"The new act will combat language barrier problems at health care facilities by providing language bridges," said Garcia, whose district includes many Spanish- and Polish-speaking constituents. "It is a historic step to alleviate the threat of potentially fatal misunderstandings."

The Language Assistance Services Act applies to hospitals licensed under the Hospital Licensing Act or long-term care facilities licensed under the Nursing Home Care Act. According to the law, those facilities may review existing policies regarding qualified interpreters, adopt and annually review a policy for

providing language assistance services to maximize use of interpreters and minimize delays in providing interpretation services, develop and post notices regarding the availability of interpreters and the procedures for obtaining their services, and identify and record a patient's primary language and dialect on the medical chart, hospital bracelet, bedside notice and/or nursing card.

The act defines a qualified interpreter as a "person fluent in English and in the necessary language of the patient, who can accurately speak, read and readily interpret the necessary second language or a person who can accurately sign and read sign language." Interpreters must also be able to translate the names of body parts and completely describe symptoms and injuries in both languages.

All health care providers who receive federal financial assistance — even those who don't treat a large percentage of foreign-speaking patients and who opt not to comply with the law's provisions — should be aware that the Civil Rights Act of 1964 prohibits them from delaying or denying health care due to discrimination based on race, color or national origin. In addition, the Joint Commission on Accreditation of Healthcare Organizations requires hospitals to have a "plan for effectively communicating in the language(s) of the predominant population group(s) served by the hospital and as needed with persons with impaired hearing or speaking skills."

However, development of these plans falls under the auspices of hospital CEOs, and there are no guidelines mandating the type of plan or details of the interpretation services to be provided by hospitals, said Glen Krasker, associate director of the JCAHO's department of performance measure interpretation.

THE IMMIGRANT AND REFUGEE Health Task Force is working with health facilities to ensure that patients who face language barriers understand their rights, according to Wendy Siegel, policy director of Travelers and Immigrants Aid, the organization that convened the task force. The task force, a citywide coalition of community organizations and health and human service providers, is also distributing "patient request for interpreter" cards printed in multiple languages.

The new law might seem to add a costly layer of personnel and paperwork to the health care delivery system, but Siegel said interpretation services are necessary from the standpoints of quality of care, compliance and liability.

"Hospitals spend thousands of dollars to bring in lawyers to draw up patient-consent and right-to-know contracts, but they think nothing of having a janitor translate the forms for non-English-speaking patients," Siegel said. "If an English-speaking patient reads and signs those forms, facilities in general are protected [from liability]. But if they grab the nearest secretary or food service worker to tell a non-English-speaking patient what the form means, it becomes a potentially complex issue legally and ethically."

Although there are no estimates for the cost of hiring qualified translators, the money is already being spent indirectly, Siegel said. "If you're pulling secretaries and other employees off their jobs, multiply the hours they spend translating by their hourly wage. Facilities might as well use that money to hire people who really know what they're doing." ■

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Data bank
institutes new reporting
procedure

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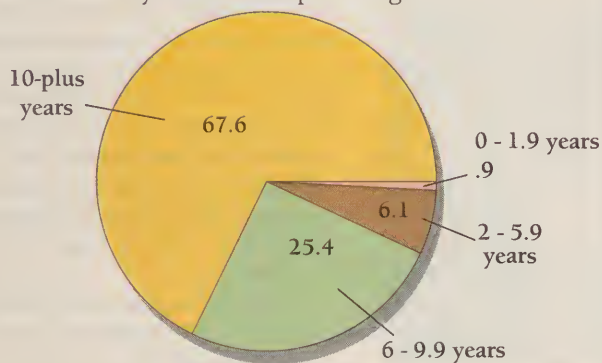
ISMIE Update

ISMIE workshop
addresses
communication

PAGE 11

Length of time policyholders are insured by ISMIE

In years and as a percentage



Source: ISMIE claims monitoring survey

MALPRACTICE ROUNDUP

Poor, elderly less likely to sue

Medicare and Medicaid patients are less likely to sue for malpractice than are patients with other types of insurance, and when they do sue, they receive smaller awards, according to a report released by the General Accounting Office. The report suggested that attorneys may be disinclined to take these patients' medical claims to court because of the patients' low earnings potential.

Average compensation for Medicare and Medicaid patients totaled \$28,000 and \$43,000, respectively, compared with about \$105,000 for other patients, according to the GAO's closed claims study. The GAO used malpractice loss data from Medicare's Hospital Cost Report Information System to determine that about one-fourth of the malpractice losses reported were paid for Medicare and Medicaid patients. ■

Advising on lower-cost care

A New Jersey appeals court said a physician can be found liable for failing to inform a patient about the availability of low- or no-cost care, according to an article in *Medical Malpractice Law & Strategy*. The court ruled in favor of a patient who sued his doctor for failing to advise him that a New Jersey medical facility could have performed the heart surgery the physician recommended for little or no cost.

In *Bundy vs. Lee*, the plaintiff — who had suffered two heart attacks — was advised by his physician to undergo heart bypass surgery. When he explained he couldn't afford the operation, the doctor continued treating him with medication, never mentioning that low- and no-cost surgery was available at a New Jersey heart and lung center. The patient suffered two massive heart attacks that permanently damaged his heart before finally undergoing bypass surgery at the center.

The defendant filed a motion for summary judgment, claiming that a medical ethicist (whom the plaintiff wanted to present as an expert witness) was not qualified to testify against a physician. The trial court granted the motion on the grounds that a doctor has no duty to a patient beyond the treatment offered by the doctor. But the appeals court disagreed, ruling that a professor of medical ethics could testify that a physician is obligated, under the duty of informed consent, to offer affordable treatment options. ■

Case in Point

Anesthesiologists should discuss dental risks with their patients

By Kathleen Furore

Presenting complaint and initial diagnosis: A patient was admitted to the hospital for minor



surgery to be performed under general anesthesia. The night before surgery, the anesthesiologist's assistant visited the patient but failed to discuss his dental history. Consequently, no record was made of the patient's permanent bridge.

On the morning of the surgery, the anesthesiologist asked the patient about previous surgeries, anesthesia, allergies and respiratory and cardiac problems. He also commented that the patient had "nice teeth" but waited until the patient was in the operating room to ask whether he had dentures, caps or "anything artificial" in his mouth. According to the circulating nurse, the

patient answered no. There was no mention of the surgery's dental-related risks.

The case in brief: After anesthetizing the patient, the anesthesiologist inserted an oral airway, which remained in place until the surgery was completed. At the end of the operation, the patient bit on the airway, causing his bridge to be ejected. The teeth attached to the bridge appeared to flip or peel up.

The resulting claim: Following his discharge, the patient was fitted with a temporary bridge and later a permanent one. He sued the anesthesiologist and the hospital for damage to his bridgework. The hospital, in turn, filed a motion for directed verdict against the physician.

The outcome of the claim: The court granted the motion for directed verdict and entered a verdict against the doctor. Although the anesthesiologist appealed the verdict, it was

upheld. The suit was settled for \$12,000.

The points this case makes: Because there is a high risk of dental injury or damage during a procedure requiring anesthesia, anesthesiologists should develop procedures to help them manage that risk. Intubation and extubation, especially, create the recognized potential for damage to teeth, caps, dentures and bridgework. Consequently, such damage is generally defensible, according to Peoria anesthesiologist Rodney Osborn, MD.

"So many of these cases are handled in the field [by physicians] that the number [of claims] doesn't even give a good representation of the occurrences," Dr. Osborn said. "Many doctors will negotiate with patients who sustain dental damage, and that is appropriate, since most claims are not that big. But I think there would be fewer problems if anesthesiolo-

(Continued on page 11)

Managed care plans increasing requests for claims information

CREDENTIALING: Physicians should consider possible consequences before releasing confidential information and signing contracts. By Kathleen Furore

[CHICAGO] As more physicians opt to participate in managed care organizations, doctors are increasingly concerned about the information they must provide before joining. Within the past few months, for example, several physicians have contacted ISMIE about the confidential information that Aetna Health Plans requires as part of its credentialing process for HMO and PPO participation.

Among Aetna's requests are a complete history of all open and

closed malpractice suits in which physicians have been involved and, in one case, permission to visit a provider's office to review medical records and observe how the office operates.

Although concerns about releasing such confidential information are justified, requests like Aetna's are becoming more common in the changing marketplace, said ISMS 10th District trustee Ronald Welch, MD, who serves as

chairman of the ISMIS Claims/Risk Management Committee. "Some organizations, especially HMOs and PPOs, have been doing this for years. Now it looks like we're changing from a provider market to a consumer market, which means there are more and more demands. And if physicians want to participate in these health care plans, they're going to have to comply."

In addition, there are no laws (Continued on page 10)

Data bank institutes new physician reporting procedure

CHANGE: Doctors may now provide their side of the story. By Kathleen Furore

[ROCKVILLE, MD.] In a move made to benefit health care providers, the National Practitioner Data Bank now allows physicians and other health care practitioners to explain their side of a reported allegation without filing a formal dispute.

Health care professionals can submit a statement regarding any medical malpractice payments, adverse clinical privilege decisions, licensure disciplinary actions or adverse membership actions by professional societies, according to Patricia Campbell, spokesperson for the

U.S. Health Resources and Services Administration, the agency that administers the data bank program. The statements, limited to 600 characters including spacing and punctuation, will not be edited, Campbell said.

"In the past, physicians couldn't file a statement unless they filed a formal dispute," Campbell explained. "Even then, the statement would remain with the report only during the dispute. With this new feature, physicians can file a statement that becomes a permanent part of the report that stays with their file. And they don't have to file a formal dispute to do so."

Because practitioners may not use the dispute process to protest an insurer's decision to settle a claim or to appeal the underlying reasons for an adverse legal action, there were previously few situations that allowed physicians to tell their side of the story, Campbell said. "Before, to file a statement, practitioners could only dispute whether the reported information was factually accurate or a

report was filed in accordance with the data bank's reporting requirements."

The new reporting procedure became effective last month, but the feature is retroactive, meaning that physicians can place statements with reports filed before March 1994, Campbell said. She also stressed that the statement feature does not preclude practitioners from filing a formal dispute. Practitioners can add a statement to a report without filing a dispute, file a dispute without adding a statement or do both, Campbell said.

Although the statements allow physicians to comment on claims against them, ISMS general counsel Saul Morse questioned its ultimate benefit to physicians. "It's hard to say what impact it will have. It does make it easier for physicians to give their side of an issue. Now they don't have to go through the difficult and time-consuming process of filing a formal dispute. But the basic issue is that there is still a lot of information reported to the data bank that certain people can get to. And in a 600-character statement, it is difficult to give the full flavor of what happened in a malpractice suit."

Because of potential misuse of information, ISMS House of Delegates policy calls for the timely dissolution of the data bank.

For more information, physicians may phone the data bank's toll-free help line at (800) 767-6732. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

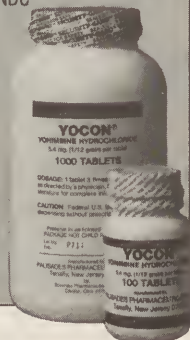
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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Managed care

(Continued from page 9)

barring requests for confidential claims information, according to ISMS general counsel Saul Morse. "The problem is that if you want to be part of a plan, that plan can set the rules for participation. If it sets the rules, and a physician says, 'I don't want to abide,' the plan [administrators] can say, 'Fine, then don't participate.' There is no effective regulation of these kinds of efforts."

OF COURSE, the fact that a physician has been threatened with a malpractice lawsuit or has gone to trial and lost does not

prove incompetence or negligence, Dr. Welch said. One out of three physicians has been sued, and of those cases that go to trial, one of seven or eight loses, he noted. Yet as Dr.



Dr. Welch

Welch and Morse observed, many managed care plans are obtaining information that could be interpreted as evidence that a physician is not sufficiently qualified to participate in the organizations.

"To the extent we've been able to discern, these plans are saying they need this information to know the qualifications of their doctors," Morse said. "They want to be able to say they have well-qualified physicians. There has been a slight increase in litigation against HMOs, in particular, in which patients complain that decisions are being based on costs and not quality or need." He said requesting thorough claims information is one way managed care plans can say they are committed to providing quality care.

"To divulge all this information and have it used in a manner that implies a

level of competence is not appropriate," said Dr. Welch. "Using this kind of information is not an appropriate way to evaluate physicians."

In most cases, physicians who want to sign contracts with plans that request detailed claims histories will have to provide that information, according to Dr. Welch and Morse. They noted steps doctors can take to allay their fears about the credentialing process.

If physicians are asked to self-query the National Practitioner Data Bank and provide a copy of the data bank report to a managed care organization, they should send a letter to plan administrators outlining the conditions under which they will fulfill the request, Dr. Welch said. In the letter, doctors should require that the report be kept confidential and stipulate that it not be used as a means to determine their competence.

The AMA, which has written a sample letter to organizations that request claims information, advised physicians to require documentation showing that the request complies with the intent and statutory protections of the Health Care Quality Improvement Act of 1986. The AMA also recommended that physicians request written assurances that the information provided will be protected from further disclosure under relevant state peer review immunity statutes and that the information will be used and maintained only for purposes such as quality assurance activities protected under state peer review immunity statutes.

Regardless of the specifics of a managed care plan's request for information, Morse offered this advice: "Physicians should really check through all the paperwork they're given before they sign a contract. They should know what it means and to what use the information they're providing is going to be put. Then before providing the information and signing the contract, they should think about what they're doing, to determine if it's worth it to them." ■

ISMIE workshop addresses physician-patient communication

A top reason patients sue is ineffective physician-patient communication, according to studies of the causes of malpractice litigation. Recognizing the risks such communication problems pose for physicians, ISMIE's Risk Management Committee is sponsoring a workshop on difficult physician-patient relationships. The program, which will be held May 11 in Oak Brook and May 12 in Springfield, is designed for physicians and their staff members who have

frequent contact with patients.

The workshop will help participants develop effective communication techniques and strategies for dealing with complex patient interactions. Faculty from the Miles Institute for Health Care Communication, which produces educational initiatives aimed at improving physician-patient communication, will conduct the program.

After completing the workshop, participants will be able to recognize which

patient relationships cause difficulty for physicians, identify common communication barriers, list approaches to overcome those barriers and determine when it is necessary to involve other professionals or family members.

Two sessions will be held at the Marriott Oak Brook Hotel – one from 7:30 a.m. to noon and another from 12:30 p.m. to 5 p.m. A single session beginning at 8 a.m. will be conducted at the Springfield Hilton.

The registration fee is \$50 for ISMIE insured physicians and their employees and \$100 for all other participants. The registration deadline is May 4; ISMIE policyholders will be given priority registration status. In addition, if space becomes limited, ISMIE reserves the right to cancel registrations for nonphysicians.

ISMS has designated the program for four hours of credit in Category I of the Physician's Recognition Award of the AMA.

For registration information, contact the ISMIE risk management department at (312) 782-2749 or (800) 782-4767. ■

Case in Point

(Continued from page 9)

gists took time [before an operation] to examine their patients, review their dental histories, document the results and discuss the risks of dental damage associated with surgery."

To minimize risk and provide optimum patient care, anesthesiologists should develop and follow procedures for discussing dental issues with each patient, said Henri Havdala, MD, chief of anesthesiology at Chicago's Mt. Sinai Hospital Medical Center and Finch University of Health Sciences/The Chicago Medical School in North Chicago.

"We always cover dental questions [before surgery]. I even have a whole section on the pre-anesthesia evaluation form for teeth questions," said Dr. Havdala, a member of ISMIE's Risk Management Committee. "The beauty of preprinted forms is everything is there. We're all human and can forget things. But if the questions are there in front of you, you will always ask. And if a patient is asked and forewarned, the possibility of a lawsuit is much less." Dr. Havdala said his form asks whether a patient's teeth are normal and whether the patient has any whole or partial, permanent or removable bridgework.

Dr. Osborn concurred, noting that in his practice, anesthesiologists discuss dental histories and surgery-related dental risks before surgery – in the pre-op area or the office. For inpatients, that discussion should occur in the patient's hospital room. He also noted the importance of checking for cracked, loose or fractured teeth, and the presence of dentures, before performing any procedure. In addition, all notations should be documented in patients' records.

"You should always ask a patient about loose teeth. Sometimes, for example, periodontal disease is so bad that it makes the gum recede and the underlying bone deteriorate, which causes teeth to become loose," Dr. Osborn said.

ISMIE risk management experts also advised physicians to include dental-related risks in the pre-anesthesia consent form signed by the patient, document dental injuries and discuss them with the patient when they occur, and notify the ISMIE claims department of any incident involving damage to oral structures.

"While an anesthesiologist may offer to pay for dental repair, it is important that there be no admission of liability," said an ISMIE risk management expert. "He or she might be told that no payment should be made, because the patient gave informed consent for the procedure and was made aware that one of the common risks was a dental injury." ■



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DEMOCRATIC PROCESS

Medicine from the bottom up

Through grass-roots participation, doctors help shape policy on the practice of medicine.

BY ANNA CHAPMAN

People who make New Year's resolutions are usually on their own in achieving them. But through ISMS' policy-making process, a resolution that begins with one person can garner support from the House of Delegates, become policy and eventually become part of ISMS or AMA programs. It can even form the basis for state legislation. And a resolution that becomes policy helps shape the Society's agenda for accomplishing its mission during the year.

Even though the issues that prompt resolutions and policy may have changed since ISMS was founded in 1840, the process has remained relatively the same. The House of Delegates was formed as a democratic policy-making body to represent members of the Society and protect the best interests of their patients, said Ulrich Danckers, MD, ISMS speaker of the house.

The House of Delegates meets at least annually to establish Society policy by voting on resolutions, Dr. Danckers explained. "The mission is fairly constant, but policy is flexible and has to be adjusted every year," he noted.

The process has proved its worth over the decades, Dr. Danckers added. "It is a textbook example of democracy."

THE PURPOSE of a resolution is to create new policy or modify, substitute or rescind existing policy. A resolution may also direct the Board of Trustees to take some action, such as prompting ISMS to contact different groups in support of a policy, preparing a model legislative bill consistent with a policy position or implementing a policy. Delegates may also submit pro forma resolutions, which make a public statement without requiring action or policy change, such as

memorial or reaffirmation resolutions.

Resolutions must be capable of being implemented, Dr. Danckers said. If ISMS legal counsel determines the requested action to be illegal or if the resolution addresses multiple unrelated issues, the speaker may reject the resolution from house consideration. Short, unambiguous resolutions have the best chance of being adopted, he noted.

During the 1994 ISMS annual meeting, 246 delegates representing 91 counties will debate and vote on some 55 resolutions. According to ISMS policy, each county medical society with at least one member elects and sends one delegate to the house. Counties with larger memberships may elect one delegate for every 75 members above 112. Most counties send one or two delegates to the house. With 9,394 members, the Chicago Medical Society is the largest county society in the state and elects 125 delegates.

The second-largest county medical society in Illinois – the DuPage County Medical Society – has 14 delegates, who have submitted 12 resolutions this year. Joseph O'Donnell, MD, a semiretired family physician from Oak Brook, has been a delegate for about 30 years. "A delegate's responsibility is to listen to physicians at the grass-roots level and communicate their concerns to the House of Delegates in a logical sequence. [He or she] must not only present the problem but also offer a solution."

The main goal of the delegates is for other house members to discuss and consider the issues raised, Dr. O'Donnell said. "Delegates should not feel bad if their resolutions are turned down. The main thing is to bring out the subject."

Only delegates and other voting members of the house may introduce resolutions, according to ISMS

DEMOCRATIC PROCESS

policy. Voting members include delegates, the ISMS president, the president-elect, vice presidents, the secretary/treasurer, the speaker, the vice speaker and trustees. Delegates may introduce resolutions under their name or on behalf of the county medical society. Resolutions submitted at the county level are discussed and modified at county society meetings before they are forwarded to the speaker for introduction in the house.

DELEGATES MAY DEVELOP ideas for resolutions from various sources, Dr. Danckers said. They may be approached by constituents with specific concerns, or they may formulate ideas based on conversations with colleagues or staff. "Not all delegates share the same opinions, but in the larger societies, individual physicians will likely find it easy to find someone who shares their views."

"It is important for nondelegates to bring forth their ideas," said James Bull, MD, a family physician from Silvis in Rock Island County, who has been a delegate for a total of six years. "Physicians get the best representation when everyone submits his or her concerns, whether at county medical society meetings or to specific delegates."

BEFORE THE HOUSE OF DELEGATES meeting, the speaker assigns all resolutions to reference committees for debate. Any ISMS member may attend those debates and may provide testimony on any issue. The proper place to defend, debate or denounce a resolution is the reference committee, not the house floor, Dr. Danckers said. Delegates who submit resolutions must attend the reference committee in which the resolution is to be considered.

After reference committee debate is closed, committee members prepare recommendations on each resolution for the house. That sometimes requires creating substitute resolutions, which may encompass several resolutions with similar intent. "Pressing problems tend to come up in multiple resolutions," Dr. Bull said.

The full house must then consider and vote on reference committee recommendations. "It's my obligation [as speaker] to remain strictly neutral and not influence the outcome of debate," Dr. Danckers said.

The house may vote to adopt a resolution, requiring the board to carry out the intent of the resolution as soon as possible, Dr. Danckers said. Or the house may vote not to adopt a resolution, in which case no further action is taken. The house may also vote to refer the resolution to the board for report, for decision or for national action.

If a board report is requested, the board must study the issue and create an unfinished business report with recommendations for final action, Dr. Danckers said. Through a referral for decision, the board is delegated the authority to determine appropriate action and report that decision to the house. Following a referral for national action, the chairman of the board determines the appropriate national action, in accordance with Executive Committee approval, and reports back to the house.

"Delegates take their jobs very seriously," said Richard Bulger, MD, an otorhinolaryngologist and four-year delegate from Hinsdale. "Many of them want to speak on every issue. They live and die by it." Dr. Bulger called the process "democracy in action" that is set in motion by "grass-roots practicing physicians and academicians doing the everyday work of medicine." ■



Medical matchmakers

Program directors weigh more than grades in resident selection process. By Kathleen Furore

On March 16, graduating medical students nationwide waited for the results of four years of anticipation. The occasion was Match Day 1994, when future residents discovered the hospitals or medical centers at which they would perform their residencies.

According to a report from the Washington, D.C.-based National Residency Match Program, 22,820 residency positions were offered and 18,877 filled in the 1994 match. A total of 9,210 medical school seniors landed spots at the institutions ranked first on their lists. Illinois medical facilities filled 1,011 of 1,200 open residency slots.

But those numbers don't tell the story of the competitive selection process — how residency programs narrow the field of candidates and make their final selections. Chicago's McGaw Medical Center of Northwestern University, for example, received some 7,000 applications for the 195 positions available in all its residency programs, according to Robert Vanecko, MD, associate dean for graduate medical education at Northwestern University Medical School. He said 192 of those spots were filled.

To understand the method behind what might appear to some to be match madness, *Illinois Medicine* spoke with residency program directors and medical school personnel throughout the state.

ALTHOUGH MEDICAL institutions — and in many cases, individual department programs within those institutions — establish their own selection criteria, all use the same basic elements to screen candidates: academic records, board scores, a letter from the dean of each student's medical school, three letters of recommendation, an autobiographical statement and a personal interview. Those who interview and evaluate prospective residents said it is unlikely a single element would throw the balance in favor of a candidate in the final selection process.

"I've never had to choose any one thing; it's always a combination of factors that helps us decide," said Ronald Kresner, MD, vice chairman and director of psychiatric education at Northwestern's department of psychiatry and behavioral sciences. "There's not any one

thing that would make me say, 'I want to have this person.'"

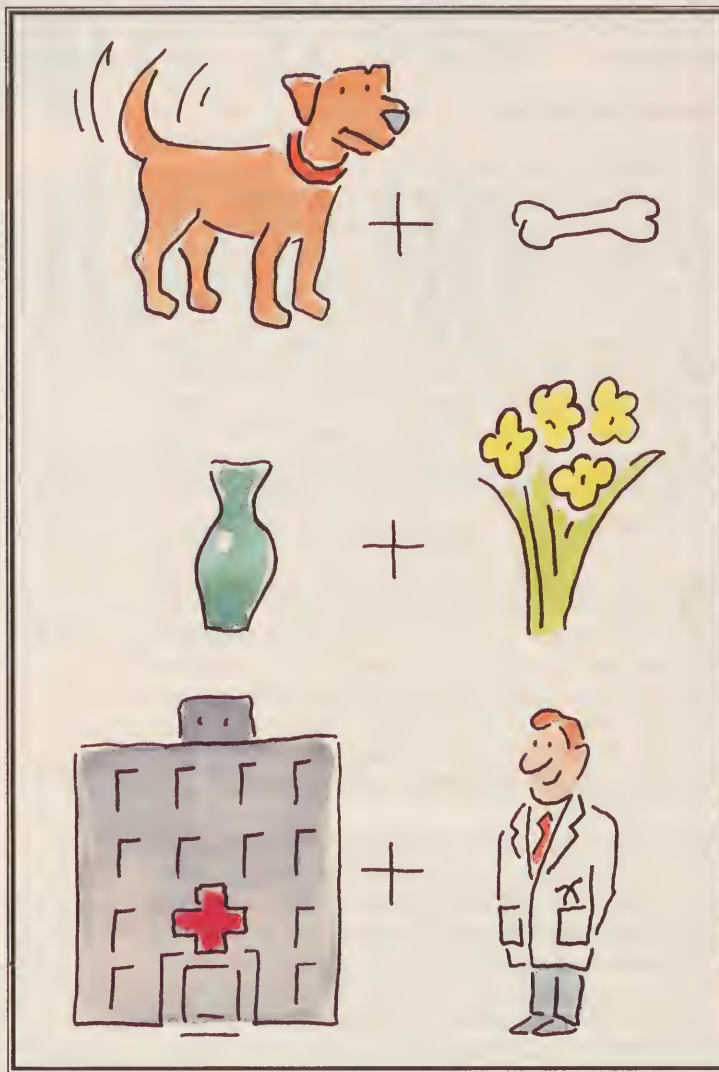
"There's not one particular thing we're looking for," echoed Marc Squillante, DO, program director for the Emergency Medicine Residency Program at the University of Illinois' College of Medicine at Peoria. "If two people are equally qualified and one has much higher board scores, it might tip the scale in his or her favor, but students can look average on paper and sell themselves in the interview. We put a lot of weight on interviews, because we want someone who will fit in well with the personalities here."

Students who've completed clinical rotations at institutions to which they're applying usually have an edge over peers with no connection to the health care facilities, according to Dr. Squillante and Gerald Suchomski, MD, director of the Belleville Family Practice Residency Program, which is part of the Southern Illinois University School of Medicine. "If someone has done a rotation here, he or she has an advantage over someone who has spent just half a day interviewing," Dr. Suchomski said. "They get to know us over four weeks and see us on good days and bad, and we get the chance to see how they do over time."

The Belleville program seeks candidates with solid academic credentials who are likely to stay and practice in Illinois, he added.

Because most medical schools use pass-fail grading systems, grades typically aren't considered as important as other information submitted with residents' applications, the residency directors said. "We look at the level of academic achievement, but there are no specific parameters," noted Jerry Kruse, MD, director of the Quincy Family Practice

Residency Program. "We do look very closely at the dean's letter because it lists all the strengths and weaknesses of a candidate. And the personal interview is very important because we want to know if someone will fit in and be happy."



FITTING IN at an institution is important for residents as well as those who will be instructing and working with them. But being well-suited to a particular specialty is even more crucial where the big picture is concerned, residency directors said. So they try to determine why students want to pursue certain areas of medicine. They also look for life experiences and personal characteristics that show that candidates have what it takes to specialize in such fields as psychiatry, family practice and emergency medicine.

When evaluating prospective psychiatry residents, Dr. Kresner said he looks for "potential therapist characteristics" and activities that demonstrate an interest in psychiatry. "During the interview, which is very subjective, we look at the way candidates present themselves, as well as their communication skills, openness, self-expression, motivation and interest in psychiatry. We want to see how they relate and respond to others, and we look at their emotional well-being and self-awareness. They also should show a humanistic orientation and an empathetic capacity."

Dr. Kresner said he considers students to be good candidates for a psychiatry residency if they have taken electives in psychiatry, earned honors in psychiatry during their clerkships, or held nonacademic positions as orderlies, medical technicians or even camp counselors.

"We look for anything that indicates students have a strong interest in people. We have one resident now who has a master's degree in cultural anthropology and another with a master's in psychology."

PROSPECTIVE FAMILY PHYSICIANS should "espouse the philosophy of FPs," said Dr. Kruse. That philosophy focuses on the "continuing, comprehensive care of the entire patient and the importance of family and community."

"The most desirable candidates exhibit true compassion for people's needs and an ability to communicate well with people," Dr. Kruse explained. Volunteering in free clinics, assuming classroom leadership roles and participating in community organizations demonstrate candidates' communication skills and adherence to the family practice philosophy, he added.

Dr. Suchomski added that ideal FP candidates "derive joy in dealing with a large variety in life."

"Family practitioners deal with babies and old people and pregnant women, and a multitude of problems ranging from colds and flu to hypertension and diabetes," he continued. "If [students] want to know absolutely everything about one area, they need to consider a subspecialty. If they want to know about the broad picture and enjoy dealing with people and community units, family practice is right for them."

"In an interview, if candidates are asked what rotation they liked best and they say, 'The problem is I liked them all,' it's not a

problem. That's why they want to be in family practice," added Dr. Suchomski.

Students interested in emergency medicine careers should be well-rounded and understand the scope and the stress of the specialty, according to Dr. Squillante.

"It sounds cliché, but we're looking for well-rounded students with outside interests and experiences," he continued. Students who volunteered in free clinics, actively participated in state and local medical societies, tutored junior med students, did research, worked part time or published papers are looked upon more favorably than those who spent all their time studying, he said. "They need to have personal interests, because emergency medicine has a lot of stress and they need to balance their personal life with their professional life."

Applicants for emergency medicine residency programs should have had some ER experience — possibly during an elective rotation or as a paramedic or EMT — and understand the diverse nature of the specialty, said Dr. Squillante. "They shouldn't be making this choice because they think they'll be spending 24 hours a day treating gunshot wounds and auto accident victims. Emergency medicine is a lot more routine than that. Treating sprained ankles, flu, coughs and colds is our bread and butter."

ISMS helps prepare future residents

Because interviews are cited as a critical step in the residency matching process, the ISMS Medical Student Section sponsors an annual seminar to answer questions and help students boost their interviewing skills. "Preparing for Residency Interviews" is conducted in the fall just before the application and matching process are under way.

"The goal of this all-day seminar is to help medical students gain a better understanding of the residency interview and match process, which is often complex and confusing," said Beth Miller, chairman of the ISMS Medical Student Section, in an open letter inviting students to attend the

program.

The workshop provides medical students with an explanation of how the match works and how residency interviews are conducted. A panel of resident physicians gives firsthand accounts of the interviewing process and offers suggestions about what to look for in a residency program. Program directors representing several specialty residency training programs also offer their perspectives about matching and interviewing.

In addition, the seminar includes a hands-on interviewing session during which students can practice interviewing skills and learn effective techniques to make a positive impression. ■

Illinois Medicine asked ISMS members how Society programs benefit doctors and patients statewide.



Ron Ackerman

Jane Arbuthnot, MD
Springfield

Testified before a legislative committee regarding the licensing of lay midwives.

"It's important for us to go out and make our voices heard. Without the ISMS legislative program, Illinois physicians would be totally disorganized. We have to have a common statement and not just have people out there on their own. If doctors try to go to Springfield and testify on their own, the legislature isn't going to hear the same strong voice of medicine. It's important for all of us to be aware that there are people devoting a lot of time and energy to these issues. We tend to take it for granted that there's going to be someone there to keep the effort organized."



Linda Henson

Stanley Bugaieski, MD
Peoria

Serves on the ISMS Committee on CME Activities, which designates medical society programs — such as risk management seminars — for CME credit.

"The CME activities committee ensures that ISMS' CME programs address the educational needs of Society members. We try very hard to fulfill the Essential Guidelines and Standards of the Accreditation Council on Continuing Medical Education. Without this program, the physicians and osteopaths who need continuing education to keep abreast in medicine would have to go to programs elsewhere. These programs may not have been subjected to the in-depth review that we conduct."

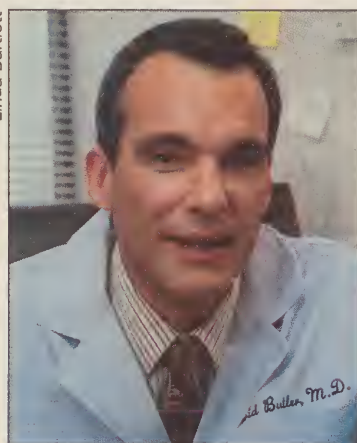


Linda Bartlett

Neil Winston, MD
Chicago

Was one of several ISMS physicians who traveled to Washington as part of an AMA grassroots lobbying effort on reform.

"As an emergency physician, I've worked in an environment in which care of the uninsured, homeless, battered and abused is an everyday reality, not just a talk-show curiosity. My involvement with ISMS enabled me to go to the nation's Capitol and share that perspective with national leaders who are directly involved in developing and implementing policies that will shape how citizens of this country receive health care. Through these kinds of ISMS efforts, I hope we can get closer to the kind of health care system those individuals deserve."



Amy Rothblatt

David Butler, MD
Elmhurst

Attended ISMS' spokesperson training workshop and has served as a public speaker on the Society's behalf.

"Participating in the ISMS spokesperson training program helped me to better prepare myself to give formal talks and to be ready for interviews. After taking the course, I participated in a panel discussion about the impact of health care reform. I think the training really helped me feel prepared and more comfortable speaking. The program is also good preparation for television and radio interviews, because you're videotaped while answering tough practice questions and critiqued by your peers."



Linda Henson

Robert Stein, MD
Peoria

Participated in the ISMS/ISMS Auxiliary mini-internship program conducted in conjunction with the Peoria Medical Society and Auxiliary Inc.

"The mini-internship program is very beneficial because it sets up a dialogue between people in the lay community and the medical profession, which helps demonstrate what goes on in a physician's office. It also helps physicians understand what members of the lay community are experiencing. With the current dialogue on health care issues, there's more awareness of the need to interrelate in this way. We need more physicians and lay leaders to participate in these kinds of ISMS and Auxiliary programs."

Managed care

(Continued from page 5)

Most patients are enrolled in the Primary Care Clinician Benefit Plan, in which patients are matched to primary care physicians close to their homes. Medicaid recipients may also choose to enroll in an eligible HMO. One-quarter of the state's 400,000 Medicaid recipients have chosen this option, Miller said.

MMS provides its physician members with managed care education and advocacy programs, Miller said. The society also analyzes managed care contracts for physicians and evaluates capitation issues and contracts, utilization review issues, the terms of claims and patient satisfaction issues. In addition, the society is pursuing legislation that requires managed care plans to accept any physician who meets the plan's criteria.

In 1991, the MMS Hospital Medical Staff Section conducted a joint survey of acute general hospitals in the state, which found that 37 percent of the state's hospital medical staffs had formed IPAs. A 1991 survey conducted by Ernst and Young found that 17 percent of medical staffs nationwide had formed IPAs.

Based on the results of a 1992 hospital survey, the society concluded that the pace at which organizational relationships are being formed between

physicians and among physicians, hospitals and other health care providers would rapidly increase. That has seemingly been the case. "In spite of the Massachusetts tradition of private solo practice and relatively few physicians in group practice, transitional forms of organizations, such as IPAs and PHOs, are being implemented rapidly and exist to the same or greater extent than nationally," MMS concluded in the 1992 survey.

A recent *Wall Street Journal* article said physicians at Massachusetts General Hospital, the state's largest teaching hospital and lead teaching site for Harvard Medical School, have been struggling to cope with managed care issues, such as pressure from health plans to release patients early. According to the article, the hospital is forming new alliances with physicians in the Boston suburbs, and a merger is planned with the hospital's major local competitor, Brigham & Women's Hospital. The merger could create the largest hospital in the United States.

Minnesota

Vertical integration is the key to successful managed care in Minnesota, said A. Stuart Hanson, MD, a past president of the Minnesota Medical Association. This involves all components in health care delivery, including physicians, hospitals and insurance plans that collabo-

rate to form single health care organizations, rather than lateral hospital consolidations or health plan mergers. A 1992 *Minnesota Medicine* article stated that in Minnesota, especially in the Twin Cities, there have been large consolidations of multispecialty clinics, hospital-physician mergers and HMO and PPO expansion. That trend is continuing, said Dr. Hanson, a pulmonary specialist at Park Nicollet Medical Center in Minneapolis.

In recent months Minnesota has seen "mergers and consolidations of hospital systems that service the Twin Cities, the amalgamation of one of the area's largest multispecialty group practices with a full-service hospital, the merger of HMOs with hospital systems, new partnerships between large group practices and a major health plan and the emergence of numerous PHOs and other physician-directed delivery systems," according to the March 1994 issue of *Minnesota Medicine*. In addition, MMA formed a joint task force with two county medical societies to plan new "clinics without walls." Physicians are also in the process of forming at least five networks in the Twin Cities area, joining the long-standing East Metro Health Organization physician network in St. Paul, the article said.

Minnesota had a 1992 HMO penetration of 32 percent, according to the *Marion Merrell Dow Managed Care*

Digest. "Virtually everyone — over 90 percent of the Twin Cities' population — is in an HMO or PPO," Dr. Hanson said. Mergers are occurring rapidly in Minneapolis and St. Paul but more slowly in the rest of the state. The driving force behind changes in the health care system in Minnesota is expanded access, he said.

"Different regions of the state are coming together to decide how they can collaborate and cooperate," Dr. Hanson said. "We've had problems in the past with antitrust. In a large metropolitan area, it's hard to show that [collaboration] restrains trade, but in smaller areas, problems arise." In Minnesota, the Department of Public Health has some authority to grant antitrust immunity for certain public collaborative efforts, he added.

The state recently formed the Minnesota Health Data Institute, a public-private venture to review hospital indicators of quality and health care consumer satisfaction, Dr. Hanson said, adding that he is the only physician representative on the board, which includes health plan and hospital administrators, nurses and business leaders. The institute will review such indicators as hospital cesarean section rates, mammography rates and childhood immunization, which will lead to greater health care accountability in the state, he said. ■

JCAHO to issue hospital quality report cards

[OAKBROOK TERRACE] The Joint Commission on Accreditation of Healthcare Organizations has introduced a new performance measurement system to stimulate improvements in patient care, measure hospital performance and generate report cards on quality for consumers and health care purchasers.

The new "indicator measurement system" is a patient-focused reference data base designed to complement the standards on which JCAHO bases accreditation decisions, officials said. The data are gathered quarterly and entered into a national data base that enables each hospital to compare its performance with that of other providers and address specific areas that need improvement, JCAHO said.

To date, 131 hospitals nationwide, including EHS Good Samaritan Hospital in Downers Grove, St. James Hospital in Chicago Heights and the University of Chicago Hospitals in Chicago, have volunteered to inaugurate the system. It will become part of JCAHO's official hospital accreditation process by 1996.

The quality report cards, which will offer consumers basic data and explanations to help them evaluate individual hospitals' performances, will be available as early as 1997.

"We expect the system to be a valuable resource for all participants, as they continue their efforts to improve the quality of patient care and meet the growing demand for health care performance data and information," said Dennis O'Leary, MD, JCAHO president.

Initially, the system will focus on measures of patient outcomes in obstetrics and perioperative care. Outcome measures for trauma, oncology, cardiovascular care, medication use and infection control, as well as other performance measures, will be phased in. ■

Blues

(Continued from page 1)

policies and programs that have been shown to be effective."

C-sections are the nation's most common surgical procedure, Dr. VanderLaan said, noting that the procedure accounts for 25 percent of all deliveries. The U.S. c-section rate was only 5 percent in the 1970s, he said. In 1992, Illinois' c-section rate was 24.6 percent, Dr. VanderLaan added.

But c-sections are risky and have caused "substantial maternal morbidity," he explained. In addition, excessive use of the procedure has contributed to the rise in health care costs, he said. In 1992, costs for an average c-section delivery were about double the cost of a vaginal delivery.

Despite the known risks and rising costs, there are several reasons that c-section rates remain high, Dr. VanderLaan said, citing as an example physicians' fear of malpractice litigation. Other reasons include elective c-sections; an increase in fetal dystocia diagnoses and labor complications caused by the shape, size or position of the fetus; the use of electronic fetal monitors to detect complications; and the decline of vaginal births for breech presentations.

Thirty percent of c-sections nationwide are performed because patients have had

previous c-sections, said conference speaker Norbert Gleicher, MD, president and medical director of the Center for Human Reproduction in Chicago. But the idea that patients who had initial c-sections should repeat the procedure for subsequent pregnancies is antiquated, said John G. Gianopoulos, MD, director of maternal-fetal medicine at Loyola University and Medical Center. "There are no good data to say we should ever have believed that," Dr. Gianopoulos said. The dogma of "once a section, always a section" stemmed from a 1917 clinical article that based its conclusion on four patients who experienced uterine ruptures during vaginal births after c-sections, he said.

Another 30 percent of c-sections fall into the "wastebasket of dystocia diagnoses," Dr. Gleicher said. And 15 percent of c-sections are performed because of breech presentations, he said, but added that decreases in this category would not lower overall rates as dramatically as would reducing repeat c-sections and procedures performed for dystocia. "If we want to address rates efficiently, these are the big players."

Only 5 percent of c-sections are performed because of fetal distress, Dr. Gleicher said. "If a doctor ever suspects fetal distress, [he or she] should go ahead with the c-section," he said, explaining that most birth-related lawsuits are filed

because the infant suffered brain damage, which usually is associated with lack of oxygen from fetal distress.

Although no ideal c-section rate exists, institutions can aim for an ideal range, Dr. Gleicher said. Blues estimates put the optimal rate between 10 percent to 15 percent of all deliveries, Dr. VanderLaan noted. However, the target range varies among institutions, depending on the number of high-risk pregnancies the hospital handles, Dr. Gleicher noted. Hospitals that typically refer high-risk patients to other institutions will have lower c-section rates, he said.

TO LOWER C-SECTION rates, hospitals can institute programs to reduce repeat c-sections and provide educational feedback about physicians' practice profiles, Dr. VanderLaan said. The Blues suggests hospitals adopt formal vaginal-birth-after-c-section guidelines, such as those developed by the American College of Obstetricians and Gynecologists. Hospitals should also precertify all elective repeat c-sections and implement VBAC education programs for patients and physicians.

"We were seeing a high percentage of Saturday-morning c-sections," said Stephen Rittmann, MD, medical director of the Alexian Brothers Health Providers Association. This trend seems to indicate that expectant mothers are scheduling

subsequent c-sections at convenient times, he added. Dr. Rittmann described how his physician IPA network was able to improve "terrible" c-section rates in two years by using an "aggressive approach to active labor progression" and maternity management programs to alert physicians about high-risk patients. Through the program, the IPA lowered its c-section rate from 27 percent to 17 percent, he said.

Other actions taken by individual Blues-affiliated institutions include implementing peer review programs to review all c-sections and providing regular OB data reports to physicians, Dr. VanderLaan said. Some departments also disclose individual physicians' statistics to the rest of the department, and institutions regularly distribute their c-section rates to other hospitals, he said.

Hospitals have also encouraged physicians to attempt external cephalic version for breech presentations and established 24-hour in-house OB call to eliminate temptations to "get the delivery over with and go home," Dr. VanderLaan said.

"I am not aware of any program approach that has ever been tried in an institution that has not been successful," Dr. Gleicher said. "One may work better than another, but whatever you try will reduce c-section rates." ■

OBITUARIES

* Indicates member of ISMS Fifty Year Club

Ashe

James D. Ashe Jr., MD, a pediatrician from Palatine, died Feb. 12, 1994, at the age of 54. Dr. Ashe was a 1965 graduate of the Medical College of Virginia Commonwealth University School of Medicine, Richmond, Va.

Atovsky

Nathan Atovsky, MD, a general practitioner from Chicago, died Feb. 19, 1994, at the age of 79. Dr. Atovsky was a 1942 graduate of the Chicago Medical School.

Dinze

Tito B. Dinze, MD, an internist from Glenview, died March 5, 1994, at the age of 69. Dr. Dinze was a 1960 graduate of the Facultad de Medicina de la Universidad de Nuevo Leon, Monterrey, Nuevo Leon, Mexico.

Frazer

Charles R. Frazer Jr., MD, a general surgeon from East St. Louis, died March 13, 1994, at the age of 77. Dr. Frazer was a 1944 graduate of Meharry Medical College School of Medicine, Nashville, Tenn.

*Gernon

John T. Gernon, MD, a urologist from Evanston, died Feb. 18, 1994, at the age of 89. Dr. Gernon was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

Greaves

Robert J. Greaves, MD, a family physician from Collinsville, died Feb. 12, 1994, at the age of 72. Dr. Greaves was

a 1944 graduate of the University of Illinois College of Medicine, Chicago.

Hoffman

Gerald G. Hoffman, MD, a pathologist from Lake Forest, died March 1, 1994, at the age of 62. Dr. Hoffman was a 1956 graduate of Northwestern University Medical School, Chicago.

Lee

Lawrence D. Lee, MD, a family physician from Manhattan, died Feb. 20, 1994, at the age of 69. Dr. Lee was a 1952 graduate of the University of Illinois College of Medicine, Chicago.

Lev

Maurice Lev, MD, a clinical pathologist from Palos Heights, died Feb. 4, 1994, at the age of 85. Dr. Lev was a 1934 graduate of Creighton University School of Medicine, Omaha, Neb.

*Maloney

Edward J. Maloney, MD, an occupational medicine physician from Palatine, died Feb. 27, 1994, at the age of 80. Dr. Maloney was a 1940 graduate of the Chicago Medical School.

Marzano

Vincent V. Marzano, MD, a general practitioner from Evanston, died Feb. 6, 1994, at the age of 76. Dr. Marzano was a 1943 graduate of Loyola University Stritch School of Medicine, Maywood.

Orelt

Jonel H. Orelt, MD, a general practitioner from Belleville, died Jan. 25, 1994, at the age of 70. Dr. Orelt was a 1952 graduate of Medizinische Fakultät Rheinischen, Friedrich Wilhelms

Universitaet, Bonn, Nordrhein Westfalen, Germany.

*Sack

Charles I. Sack, MD, a general practitioner from Gurnee, died Feb. 23, 1994, at the age of 85. Dr. Sack was a 1937 graduate of the Deutsche Universitaet Medizinische Fakultät, Praha, Czechoslovakia.

Schwartz

Charles M. Schwartz, MD, an orthopedic surgeon from Chicago, died Feb. 12, 1994, at the age of 47. Dr. Schwartz was a 1974 graduate of the Chicago Medical School.

*Spellberg

Mitchell A. Spellberg, MD, a gastroenterologist from Chicago, died Feb. 28, 1994, at the age of 85. Dr. Spellberg was a 1934 graduate of Loyola University Stritch School of Medicine, Maywood.

Van Dorf

Nathaniel Van Dorf, MD, an otolaryngologist from Evanston, died Feb. 13, 1994, at the age of 88. Dr. Van Dorf was a 1931 graduate of the University of Illinois College of Medicine, Chicago.

Vercoe

James L. Vercoe, MD, a pediatrician from Wheaton, died March 5, 1994, at the age of 66. Dr. Vercoe was a 1955 graduate of the University of Michigan Medical School, Ann Arbor, Mich.

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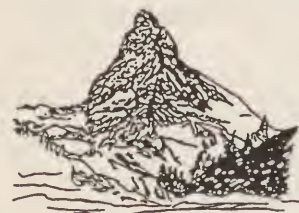


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Anti-tobacco campaign

(Continued from page 1)

The AMA's four-week "How to Quit" program – one component of the National Wellness Stop-Smoking Campaign – includes instructional videos, stress management audiocassettes, a diary and calendar on which smokers can mark their progress, a stop-smoking contract to underscore participants' commitment to quit, access to a 24-hour support hot line and a letter to employers asking for encouragement for participants in their work environment. The kits cost \$69.95 and are available at General Nutrition Centers throughout the country. A portion of the proceeds from each kit will be used to provide kits to those who cannot afford them, and AMA royalties will be used to fund public health programs.

In addition, weekly support group meetings will be broadcast on American Medical Television on CNBC every Saturday at 2 p.m. According to the AMA, these are the first stop-smoking classes to air on national television. The groups will be conducted by physicians.

"The AMA is now striking back by using the power of television to enable [smokers] to quit and stepping up our efforts to protect nonsmokers and the young from this deadly habit," Dr. Smoak said.

PHYSICIANS CAN PARTICIPATE in the program by enrolling in "Butting in: Helping Your Patients Quit," an AMA-developed continuing medical education course that will also air on American Medical Television on CNBC. The one-hour course will provide smoking-intervention strategies recommended by the National Cancer Institute and new AMA guidelines for diagnosing and treating nicotine addiction. The course will be shown on May 7 and May 28 at noon.

"Studies show that if only half of U.S. physicians helped just 10 percent of their patients stop smoking, there would be 2 million fewer smokers each year," Dr. Smoak noted. "The National Wellness Stop-Smoking Campaign is designed to bring a physician into [the] living room of every smoker in America."

The wellness campaign also includes AMA-backed legislation calling for the U.S. Food and Drug Administration to regulate tobacco as a drug-delivery device for nicotine and for increased efforts to ban smoking in all public places, according to the AMA. The AMA's list of public places in which smoking should be prohibited includes open and enclosed stadiums, mirroring ISMS House of Delegates policy.

According to the AMA, about 75 percent of the nicotine from a smoked cigarette drifts into the atmosphere, and passive smoke contains higher concen-

trations of toxic chemicals than smoke inhaled from a cigarette. "If a nuclear power plant was emitting 'passive' radiation that killed 3,000 people a year, we would not accept it," Dr. Smoak said. "Environmental tobacco smoke causes lung cancer in nonsmoking adults, resulting in 3,000 deaths a year. Behavior should not be legislated, but when one person's habits cause harm to another person's life and health, that's where the line must be drawn."

THE AMA'S MODEL legislation to ban smoking in public places specifically prohibits smoking in restaurants and bars, all workplaces and near building entrances, hospitals and other medical facilities, schools and on all airline flights that land in or depart from the United States. The bill also includes a maximum fine of \$5,000 a day for violations.

The AMA is also attacking the tobacco industry head on, calling for a ban on tobacco advertising promotional items – like T-shirts, mugs and lighters – that feature cigarette company logos. In addi-



"No. I don't mind if you smoke – as long as you don't mind if I throw you through that wall."

tion, the AMA wants to eliminate tobacco company endorsements of sports events, including prohibiting athletes from promoting cigarettes and smokeless tobacco. The AMA campaign also calls for larger warning labels on cigarette packages and a ban on coupons and free samples of tobacco products and on the sale of cigarettes in vending machines.

Dr. Seward said he is confident the AMA's anti-tobacco proposals will be successful in Congress. He added that efforts to pass anti-smoking legislation are "gathering steam." ■

ISMS services

(Continued from page 1)

managed care, ISMS has established a new toll-free number – (800) 632-7478, or MDASIST. Physicians may call this hot line Monday through Friday between 8:30 a.m. and 4:45 p.m. to speak with staff members who can address questions about managed care, Dr. Traugott said. Difficult questions will be promptly referred to managed care experts, he noted. Members who have questions unrelated to managed care or who want information about ISMS' other services are encouraged to call the Society's toll-free number (800) 782-ISMS.

ISMS PHYSICIAN members may also use the MDASIST line to access the Society's new Legal Services Referral Program. Because the medical marketplace is becoming more complex, many members have requested referrals to attorneys.

"More physicians are saying they need legal advice," Dr. Traugott explained. "Among the legal services in which physicians have expressed interest are contract review, tax advice and help in setting up payment practices that do not violate fraud and abuse regulations. ISMS wants physicians to be able to spend time treating their patients, not scanning the phone book for a lawyer."

The attorneys participating in the referral service were carefully screened by ISMS and were recruited from all around the state. Any fee agreements reached, as well as all discussions between physicians and attorneys, will be confidential.

"We've tried to make sure that these are all lawyers who have experience in health care and who are able to advocate from the physician's perspective," said ISMS general counsel Saul Morse. "We'll be making follow-up contacts with members who use the service to obtain their opinion of the program and their attorney. We hope to expand the number of attorneys involved as the need increases."

ISMS will maintain frequent contact with those lawyers to update them on Society developments and share information, Morse said.

To request a referral, physicians should call the MDASIST hot line. Information about members' needs will immediately be forwarded to members of ISMS' legal

department, who in turn will make an appropriate referral.

These services are the first results of ISMS' Medical Leadership Initiative. Physicians around the state have been providing critical input to Society staff, and the creation of the referral

vice and MDASIST hot line was based on information received from doctors statewide. Additional programs – including a feasibility study about ISMS' development of an HMO, an IPA, a clinic without walls or other managed care option – are already under way. Details about those new services will be announced soon.

"Please don't let the changes in health care delivery catch you by surprise," Dr. Traugott said. "Call ISMS and let your physician leadership know about your concerns and how the Society can best help you adapt to the health care environment of the '90s." ■

ISMS wants physicians to be able to spend more time treating their patients, not scanning the phone book for a lawyer.

Optometrist bill

(Continued from page 1)

sions are ineffective because they will not result in cost savings, and cost containment is a vital component of any health care reform legislation. Instead, Dr. Traugott recommended that legislators consider measures to expand access and make health care more affordable. Those measures include enacting tort reform, limiting pre-existing condition exclusions and making insurance portable.

"Adding providers to the system will increase the volume of tests and services performed," Dr. Traugott continued. "Inserting another provider between the patient and the physician he or she ultimately needs frequently delays treatment and makes it more drastic and expensive in the long run."

Dr. Traugott outlined the potentially serious health risks patients will face if optometrists are allowed to diagnose and prescribe medication. For example, an optometrist might fail to recognize that a patient's vision problem resulted from medication prescribed by another physician, he said.

"The human body is a single interrelated entity and not a disassociated amalgamation of parts," Dr. Traugott said. "Physicians are the only health care professionals who have the years of supervised clinical training necessary to understand the interrelationships, accurately diagnose medical conditions and effectively prescribe treatments."

Under current law, optometrists may attempt to detect eye abnormalities but are not permitted to diagnose ocular diseases, said Richard Paul, executive director of the Illinois Association of Ophthalmology. Several of the association's members attended the legislative hearing and submitted witness slips stating their opposition to the bill.

According to Paul, optometrists consider themselves primary care providers and an entry point into the health care

system. But because optometrists are not qualified to refer to providers other than ophthalmologists, expanding their scope of practice to include diagnosis and use of therapeutic ocular pharmaceuticals could increase public risk, Paul explained. And although ophthalmologists are qualified to provide all aspects of eye care, even general ophthalmologists must occasionally refer patients with complex eye diseases to subspecialists, he said.

"Most malpractice cases adjudicated or settled against optometrists relate either to misdiagnosis or failure to diagnose – a lack of recognition of a specific disease," Paul said. He cited a recent case in which an optometrist was unable to detect any ocular abnormality in a patient whose vision was failing. The optometrist referred the patient to a neurologist. Finding nothing wrong, the neurologist referred the patient to an ophthalmologist, who diagnosed glaucoma. Because the optometrist failed to refer the patient to an ophthalmologist immediately, proper treatment for the disease was significantly delayed, Paul said.

Former state legislator Robert Regan also testified against S.B. 1207. He told the committee that he would have lost his sight if his optometrist had not referred him to an ophthalmologist. The physician diagnosed and treated Regan's glaucoma. Regan noted that the drugs prescribed for his condition are easily affected by other medications, and he said he feared that expanding optometrists' use of medications could cause grave consequences for individuals in similar situations.

Dr. Traugott added that if S.B. 1207 passes, it will jeopardize the high-quality care that exists in the current health care system. This bill will "blow the starting whistle for a long parade of nonphysicians who want to practice medicine under licenses won through the legislative process rather than earned in medical school." ■

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Medicine

ILLINOIS STATE MEDICAL SOCIETY • MAY 6 1994

Governor's reform proposal advances in legislature

PAGE 4

Illinois DUR program progresses

PRESCRIPTIONS: Board develops criteria for reviewing Medicaid patient profiles. By Kathleen Furore

[CHICAGO] Complying with the Omnibus Budget Reconciliation Act of 1990, the Illinois Department of Public Aid's Drug Utilization Review Board met March 30 to discuss the criteria it will use to select patient profiles and review drug use patterns of state Medicaid patients. Under OBRA '90, states are required to implement programs that assess drug usage data based on explicit peer-reviewed screening standards.



Dr. Johnson

The 13-member, multidisciplinary committee of physicians, pharmacists and IDPA representatives has developed and approved its bylaws and is now creating screening guidelines that will differentiate Illinois' DUR program from those used by other states, said DUR board chairman Eugene Johnson, MD.

"Our first and most impor-

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Indigent care clinic moves forward

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Collaboration in Quincy

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Matt Ferguson

AT THE RECENT ISMS Annual Meeting, newly installed ISMS President Alan M. Roman, MD (right), honors outgoing president Arthur R. Traugott, MD, for his contributions during the past year. Dr. Roman's tenure as president began April 24. As the Society's official spokesperson, he will represent Illinois physicians in communications with lawmakers, the media and other groups.

Tobacco industry comes under fire

SMOKING: New reports on nicotine content and adolescent tobacco use point accusing fingers at cigarette makers. By Kathleen Furore

[WASHINGTON] The tobacco industry was hit hard by recent reports it has increased the nicotine content of cigarettes, hidden information about chemicals added to cigarettes and used advertising and promotion targeted at young people to increase sales of cigarettes and other tobacco products.

At an April 13 press conference, U.S. Rep. Henry Waxman

(D-Calif.), chairman of the House Subcommittee on Health and the Environment, criticized the tobacco industry for withholding information and misrepresenting the truth about concentrations of nicotine in cigarettes. And in mid-March, the U.S. Centers for Disease Control and Prevention published a report by the Surgeon General that underscored the

serious consequences of tobacco use and accused the tobacco industry of indoctrinating youth with tobacco promotion at a susceptible time in their lives.

According to Waxman, not only have tobacco industry executives known about the addictive nature of nicotine for years, but they have also proposed using more of it to main-

(Continued on page 14)

Hospital debuts patient care teams

INNOVATION: Officials say new approach will cut costs and increase quality. By Kathleen Furore

[WINFIELD] In what hospital officials predict is the wave of the future, Central DuPage Hospital in Winfield has adopted a cost-effective, team approach to deliver nonclinical patient care.

The hospital is hiring and training patient care technicians, patient support associates and administrative associates who will work in teams to perform many of the time-consuming, nonclinical and administrative tasks that are now performed by nurses, housekeeping staffers and unit secretaries, said Barbara Lockwood, vice president of patient care ser-

vices. The new patient care teams will be phased in on hospital units over several months, Lockwood said, adding that the first unit is scheduled to "go live" on May 23.

The 155 new patient care technicians will draw blood, perform simple physical and respiratory therapy procedures, bathe patients and handle other

tasks that don't require a nursing license, Lockwood said. "Nurses will still check wounds and do all the things that require professional judgments," she explained. The technicians will receive two months of rigorous training. Although it is not a prerequisite, Lockwood said the hospi-

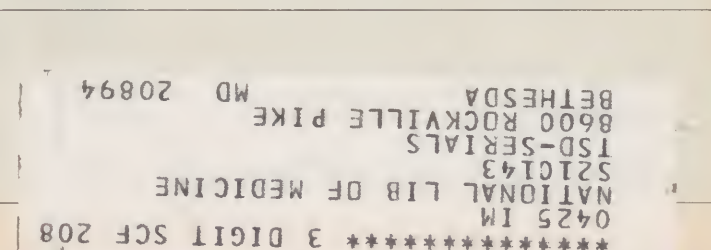
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Call to action

A proposal calling for a \$350,000 cap on noneconomic damage awards in medical malpractice cases was for the first time successfully amended onto health care reform legislation in the U.S. House Ways and Means Health Subcommittee. ISMS believes this is a laudable first step but the Society is continuing its fight to achieve a \$250,000 cap here in Illinois.

In addition, legislation has been introduced in Congress providing antitrust relief for physicians. The Health Care Antitrust Improvements Act of 1993 creates a level playing field for physicians to advocate for quality patient care.

Call your U.S. representative and senators and urge them to support legislation that includes physician antitrust relief and tort reform. If you aren't sure of your congressional district or representatives, contact the ISMS governmental affairs division at (312) 782-1654 or (800) 782-ISMS.



Illinois AIDS cases increase

[SPRINGFIELD] The U.S. Centers for Disease Control and Prevention's expanded definition of AIDS was responsible for all but 2 percent of the nearly 60-percent increase in AIDS cases reported in Illinois in 1993, according to the Illinois Department of Public Health. Last year, 3,012 AIDS cases were reported, bringing Illinois' cumulative total to 11,245 – the sixth-highest total in the country.

The CDC's new definition includes all HIV-infected individuals with less than 200 CD-4 cells per microliter of blood and adds pulmonary tuberculosis, invasive cervical cancer and recurrent pneumonia to the 23 AIDS-complicating illnesses previously listed. Consequently, many cases previously unreported were included in the 1993 statistics, because those patients fit the expanded definition, IDPH said. Specifically, 1,944 of the 1993 cases reflected the previous definition, while an additional 1,068 were reported because they met the new criteria, according to the department.

The fastest growing categories of AIDS patients reported in 1993 but classified according to the old definition were IV-drug users, women, heterosexuals and African-Americans, according to IDPH. Although homosexual and bisexual men represented the highest percentage and largest number of AIDS cases reported in 1993, for the first time, that group accounted for less than half the year's total, IDPH said.

"More and more cases are attributable to injecting drug use and heterosexual transmission, which has resulted in a noticeable increase in the number of women affected by the AIDS epidemic," according to IDPH Director John Lumpkin, MD. ■

Hispanics at high risk for diabetes

[WASHINGTON] Physicians treating Hispanic patients should look for symptoms of diabetes, according to information released by the American Diabetes Association. ADA statistics reveal that Hispanics are twice as likely to develop diabetes as non-Hispanic Caucasians, that one of every 10 Hispanic individuals are victims of the disease and that one of every four will have diabetes after age 45. Because symptoms can present so gradually, the ADA estimates that half the Hispanics who have the disease are unaware of it.

The ADA is taking steps to ensure that Hispanics recognize the signs and understand the control of the disease. The organization has reported early success in a community outreach program piloted in eight states last year. Although Illinois does not participate in the formal DAR program, an ADA spokesperson in Chicago said the state offers a variety of programs and services targeted at minorities who have diabetes or are at risk.

"We have [community-based] education programs that deal with the symptoms of and treatments for diabetes," the spokesperson explained. She added that those efforts are important, since the ADA estimates some 52,000 Hispanics have diabetes in Cook County alone. She also noted the ADA operates a 24-hour, toll-free diabetes hot line in English and Spanish. ■

Mentally ill inmates don't always pose largest threat

[CHICAGO] Contrary to long-held stereotypes, mentally ill jail inmates are no more likely to commit violent crimes after their release than are criminals with no history of mental disorders, according to Northwestern University Medical School researchers.

In a study published in the April issue of *American Psychologist*, researchers presented findings from evaluations of 728 male jail inmates – 409 of whom were diagnosed with schizophrenia; major affective disorders such as depression, alcohol and drug disorders; or psychotic symptoms such as hallucinations and delusions. Half the inmates had been charged with misdemeanors and half with felony crimes.

After reviewing six-year follow-up arrest data, researchers found that although nearly one-half of the inmates had been arrested for a violent crime, severe mental or substance abuse disorders did not affect the probability of future arrest or the number of arrests for violent crimes. "Our major finding – that [mental] disorder was irrelevant to the probability of arrest for violent crime after release – has important public policy implications," the researchers concluded. "Mental disorder alone is not a meaningful variable when deciding who should be released before trial or given probation."

The study shows that mental health professionals must learn to predict violence more accurately so that they can better balance their responsibility to treat offenders who have mental disorders with their obligation to protect the public, said researcher Linda Teplin, director of the Northwestern University Psycho-Legal Studies Program. ■



ISMS EIGHTH DISTRICT trustee Robert Welke, MD (right), and his wife, Susan (third from right), keep pace during the 15th annual Sportmart Shamrock Shuffle, an 8K run held in Chicago March 27. Running with Dr. and Mrs. Welke are (from left) ISMS staff members Al Allphin, Carol Caprio, Rob Johnston and Dawn Becker.

Private label OTC drugs gaining market share

[CHICAGO] Private label nonprescription medications are threatening to banish secondary brands from retail shelves, according to a story in the March 1994 issue of *Med Ad News*. The article said over-the-counter remedies bearing stores' own labels accounted for about 14 percent of nonprescription drug sales in 1992 but acceptance of private label merchandise has not cut into

the popularity of leading drug brands.

"You see knock-offs of only the No. 1 and 2 major brands. These are the ones the private labels go after, but it's the smaller brands that get knocked out of the picture, and private labels essentially take their place in the market," said Kathryn Griffie, a manager with Kline & Co. Inc., a consulting and marketing firm.

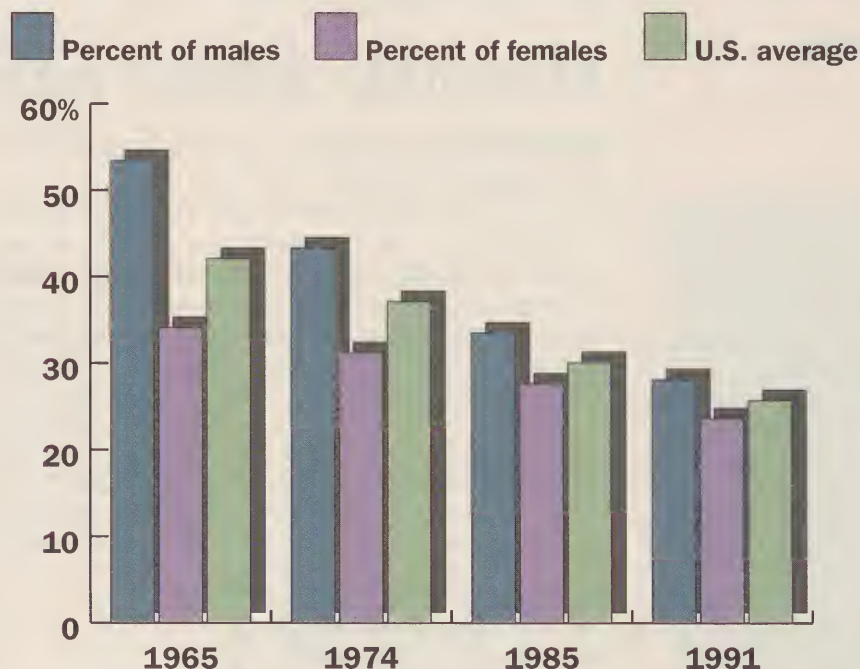
Although sales of private label OTCs have increased just 1 percent annually since 1990, statistics from the Private Label Manufacturers Association of New York revealed that private label unit share is burgeoning in almost every OTC category, according to the story. In 1993, for example, the share of store brand OTC vitamins increased 3.3 percent, laxatives 2.9 percent, nasal sprays 2.7 percent and internal analgesics 2.2 percent. Griffie predicted that use of private label OTC products like antidiarrheals and antacids, which consumers perceive as "real medicines," will eventually increase, along with sleeping aids and feminine yeast infection remedies.

Analysts attributed the boom in private label OTC pharmaceutical sales to consumers' economic concerns and their willingness to toss brand loyalty to the wind. Private label yeast-fighting products, for example, sell for between \$8 and \$10, while national brands of similar products carry price tags that range from \$12 to \$15, according to the story. And Kline & Co.'s research showed that only 20 percent of U.S. consumers are loyal to any one brand, the article said. ■

PHYSICIAN FACTS

Adults who kicked the habit

The U.S. Surgeon General's report on the health risks of smoking was released 30 years ago. Since then, the following percentages of Americans over 18 have stopped smoking. Data from 1992 show that smoking may be increasing.



Sources: Surgeon General's Report 1989, *Journal of the American Medical Association*, Action on Smoking and Health, Centers for Disease Control and Prevention

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Indigent care clinic moves forward

PROBLEM SOLVING: Appointment of a new board of directors is the first step in complying with federal regulations to maintain critical funding. By Kathleen Furore

[CHAMPAIGN] After more than a year of administrative problems, Champaign's Frances Nelson Health Center, a clinic for the medically indigent, appears to be back on track with the appointment of a new 15-member board of directors. All 13 members of the previous board tendered their resignations when the new group was approved, according to Nicholas Louis, MD, regional program consultant for the Chicago office of the U.S. Public Health Service, an agency of the Department of Health and Human Services. The agency currently has oversight of the facility, Dr. Louis said.

The center, founded in 1967, has been operating with the help of federal grants since December 1979. But internal conflicts jeopardized the \$425,000 grant on which the clinic has relied, said Dr. Louis.

"There was never an intentional effort to shut off funds, but no one at the center was responding to our requests for information," he explained. "And when we would call, there was no follow-up. We were accountable for the expenditure of public funds, and we saw the center as nonfunctional. That's why we conditioned the grant; we wanted to get their attention, so that they would take the measures needed to continue receiving funds."

To remain eligible for government assistance, the health center had to meet one key condition: It had to create a task

force to appoint a new board, which unlike its predecessor, would comply with federal regulations, Dr. Louis said. Those regulations require that at least 51 percent of the board members use the center themselves and that they reflect the age, gender and race of the center's patients, he noted, adding that the rest

of the board must represent the community at large.

THE HEALTH CENTER is currently operating on a six-month grant from HHS, which extends through May 30. After determining whether the board complies with all federal regulations and has fulfilled

conditions of the grant, HHS will decide on future funding, Dr. Louis said. Those conditions include revising the center's bylaws, hiring a new executive director and filling provider vacancies created by the resignation of many medical staff members, he added.

"The task force has appointed the new board and revised the bylaws. We're impressed by what the task force has done and with everyone's willingness to do what is needed to address the conditions at Frances Nelson," Dr. Louis noted. "I think things are taking shape in a very positive way." ■

Blue Cross
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REPORT

FOR *Illinois Physicians*

MEDICARE PART B BILLING SERVICES FOR IMMEDIATE RELATIVES

According to Medicare Part B guidelines, payment may not be made for expenses which constitute charges by immediate relatives of the beneficiary or members of his or her household. The intent of this exclusion is to bar Medicare payment for personal services of providers which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. Medicare **actively** pursues overpayments when providers bill for immediate relatives or members of their households.

The following degrees of relationship are included within the definition of "immediate relative":

- husband or wife
- natural parent, child, and sibling
- adopted child and adoptive parents
- stepparent, stepchild, stepbrother, and stepsister
- father-in-law*, mother-in-law*, son-in-law, daughter-in-law, brother-in-law+, and sister-in-law+
- grandparent and grandchild

(* = A father-in-law or mother-in-law relationship does not exist between a provider and his spouse's stepfather or stepmother.)

(+ = A brother-in-law or sister-in-law relationship does not exist between a provider and the spouse of his wife's [or husband's] brother or sister.)

A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. For example, if a physician treats his stepfather after the death of the physician's natural mother or after the stepfather and natural mother have divorced, or if he treats his father-in-law or mother-in-law after the death of his wife, the services are considered to have been furnished to an immediate relative, and, therefore, are excluded from coverage.

"Members of the beneficiary's household" are defined as persons sharing a common abode with the beneficiary as part of a single family unit, including those related by blood, marriage or adoption, domestic employees, and others who live together as a single family unit. Roomers or boarders are to be included in the definition.

ISMS, Kane County to co-sponsor health care reform forum

ISMS and the Kane County Medical Society, along with U.S. Rep. J. Dennis Hastert (R-Batavia), will co-sponsor a program providing a status report on the health care reform process. "Health Care Reform '94: The Emerging Bipartisan Consensus" will be held May 23 at the Pheasant Run Convention Center and Resort in St. Charles.

Hastert sits on the House Energy and Commerce Committee, which considers health care legislation. He will provide an update on the politics of achieving health care reform and explain how far the reform effort has progressed in the legislative process.

The day-long program will also feature presentations by key players in the health care debate and present case studies illustrating the successes and failures of the current system. In addition, local health care experts, including physicians, will participate in a panel discussion about major reform issues.

For more information about the program, contact the ISMS governmental affairs division at (312) 782-1654 or (800) 782-ISMS. ■

Governor's reform proposal advances in legislature

BILLS: Edgar attempts to expand access by providing affordable insurance plans. By Anna Chapman

[SPRINGFIELD] As promised in his State of the State address, Gov. Jim Edgar introduced legislation April 13 allowing Illinois employers to form

insurance pools to provide health care coverage for their employees. The bill, which passed the Senate and is in the House, is sponsored by Sens. John Mait-

land Jr. (R-Bloomington) and Robert Madigan (R-Lincoln). It creates the Health Purchasing Group Act, which was designed under Edgar's direction by his Health Care Reform Task Force.

"The package I am forwarding to the General Assembly for action this spring will not create a new bureaucracy or require extra dollars from the state treasury," Edgar said. "It will allow businesses large and small to form insurance pools to manage their health care costs and workers to obtain affordable insurance between jobs."

Edgar's reform legislation also includes a proposal that enables employees who are between jobs to purchase low-cost, "no frills" health insurance. Current federal law allows terminated employees to purchase the same coverage they had while they were employed, but usually at significant cost.

"Portability of health insurance is an important issue for many workers who lose their jobs or want to transfer to a new one. They're understandably concerned that they will lose health benefits for themselves and their families at a time when their income may have been reduced. Far too many workers simply cannot afford the current expensive option of extending their coverage through their former employers," Edgar said.

Edgar's proposed coverage extension alternative also reduces — and in some cases eliminates — waiting periods for coverage under any plan with a new employer, he said.

Legislative debate on other bills affecting medicine is ongoing in the state Capitol. As *Illinois Medicine*

went to press, the deadline was approaching for bills to emerge from committee in their house of origin. Measures that have been acted on to date include the following:

BIRTHING CENTERS — Rep. David Phelps (D-Eldorado) and Sen. Karen Hasara (R-Springfield) introduced legislation in the House and Senate again this year aimed at establishing freestanding birthing centers as alternative health care models. Their attempts to pass similar legislation last year failed. The bills, H.B. 3406 and S.B. 1652, amend the Alternative Health Care Delivery Act by calling for the creation of birthing centers with no more than 10 beds, which would serve as delivery centers for women "following a normal, uncomplicated and low-risk pregnancy."

ISMS opposes the measures, in part, because they include provisions permitting the facilities to be "physically distinct from a hospital." According to ISMS House of Delegates policy, birthing centers must adhere to American College of Obstetricians and Gynecologists guidelines, which require that such centers be attached to hospitals.

H.B. 3406 failed to advance in the House Health Care and Human Services Committee by one vote April 14. S.B. 1652 was not reported from the Senate Rules Committee.

MEDICAID REIMBURSEMENT — Testimony was heard but no vote was taken in the House Health Care and Human Services Committee April 14 on a bill allowing direct Medicaid reimbursement for certified nurse practitioners. Sponsored by Rep. Carol Ronen (D-Chicago), H.B. 3885 amends the Illinois Public Aid Code and enrolls nurse practitioners as Medicaid primary care providers for children and pregnant women. According to the legislation, as primary care providers, the nurses will receive reimbursement at 90 percent of the rate paid to physicians. An identical bill, S.B. 1505, was introduced in the Senate by Sen. Jim Rea (D-Christopher) and was not reported from the Senate Rules Committee.

ISMS opposes the legislation because physicians advocate a collaborative relationship between themselves and nurse practitioners instead of a potentially autonomous situation in which nurse practitioners receive direct reimbursement.

In December 1993, Illinois Attorney General Roland Burris rendered an opinion on the issue of direct reimbursement for nurse practitioners in response to a request from Phelps, who chairs the Health Care and Human Services Committee. In the opinion, Burris says that the "state is required to offer direct Medicaid reimbursement to reg-

istered nurses who are properly certified." However, Burris' opinion failed to define which medical services, if any, certified nurse specialists are allowed to provide under state law.

Under the supervision of physicians, nurses with advanced degrees can carry out functions such as conducting health screenings and providing follow-up care to physician visits. ISMS believes that inadequate supervision of nurse practitioners could create quality of care concerns.

LICENSING — A lay midwife certification bill, sponsored by Rep. Jan Schakowsky (D-Evanston), failed to advance in committee April 14. The bill, H.B. 3256, would have required the licensing of lay midwives through the Illinois Department of Public Health, not the Illinois Department of Professional Regulation, which licenses all other professionals. The bill also would have established an 11-member advisory committee within the public health department to implement the act and revise rules, conduct disciplinary hearings and recommend educational requirements. ISMS opposed the legislation. ■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

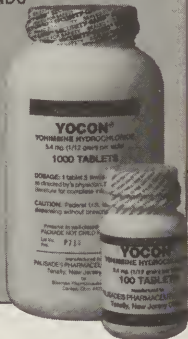
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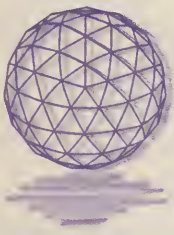
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Collaboration in Quincy

The health care community creates a PHO to integrate delivery of services. By Anna Chapman

To meet the challenges of the changing health care marketplace, Quincy's hospital and largest physician clinic have formed a physician hospital organization. The 50-50 partnership between Blessing Hospital and the 60-physician Quincy Medical Group is the result of a managed care strategic plan the group developed several years ago, said William Sullivan, the medical group's administrator. Before May 1, the multispecialty physician group had been called the Quincy Physicians and Surgeons Clinic.

MANAGED CARE



"To be consistent with health care reform, our clinic wanted to align with a hospital to integrate health care services in the area," Sullivan explained. "We formed the PHO basically to get to know each

other. The success of health care delivery of the future will depend on core groups of physicians and hospitals working together."

The PHO, Quincy Health Care Management Inc., is a freestanding business corporation, Sullivan said. "We are a professional service corporation within a well-established group practice, with a board and physician governance." One of the PHO's goals is to pool physician resources to "manage risk in the changing game of managed care," he added.

The PHO's service area lies within a one-hour radius of Quincy and includes a population of 200,000. The area also includes several Missouri counties, since the city is located on the Mississippi River.

THE QUINCY HEALTH CARE market changed several years ago when a health care business coalition formed in the city and organized a PPO, said Brad Billings, Blessing's chief operating officer. Blessing negotiated with the coalition but found that its approach was not the most effective, he added. "That gave us the impetus to move forward with the PHO."

The PHO was officially formed in March 1992 by the physician group and the town's two hospitals at that time — Blessing and St. Mary Hospital. But until May 1 of this year, the PHO's only managed care venture had been Tri-State Rehabilitation Services, which began in March 1993, Sullivan said. Blessing became the sole hospital partner in the PHO when it purchased St. Mary's in April 1993, Billings said.

To prepare physicians for what lay ahead, the hospital and clinic provided educational programs on managed care and capitation, Billings added. "The physicians have had an evolving attitude toward managed care. Many have said, 'Let's get the ball rolling. We can't move forward unless we're proactive.'"

The PHO includes two managed care products — an HMO and a PPO, Billings said. The PPO began operation May 1, Sullivan noted. Although most of the doctors in Quincy are in the group, the PHO plans to recruit other independent physicians so that the PPO can create a primary

care network in the area, Sullivan added.

Practicing within the HMO, physicians will enter the "strange world of capitation," Billings said, adding that the PHO will contract with an HMO to provide care to state employees in the area beginning July 1. The Illinois Department of Central Management Services recently announced it is offering expanded health plan choices for state

workers, including an HMO option. The Quincy PHO will manage one of the 16 HMO plans that will be available throughout the state, according to CMS.

"We needed to get our feet wet, so we limited HMO participation to only that group," Billings said. Initially, the HMO product will be narrower in scope than the PPO product because more risk is involved, he explained. "We need to

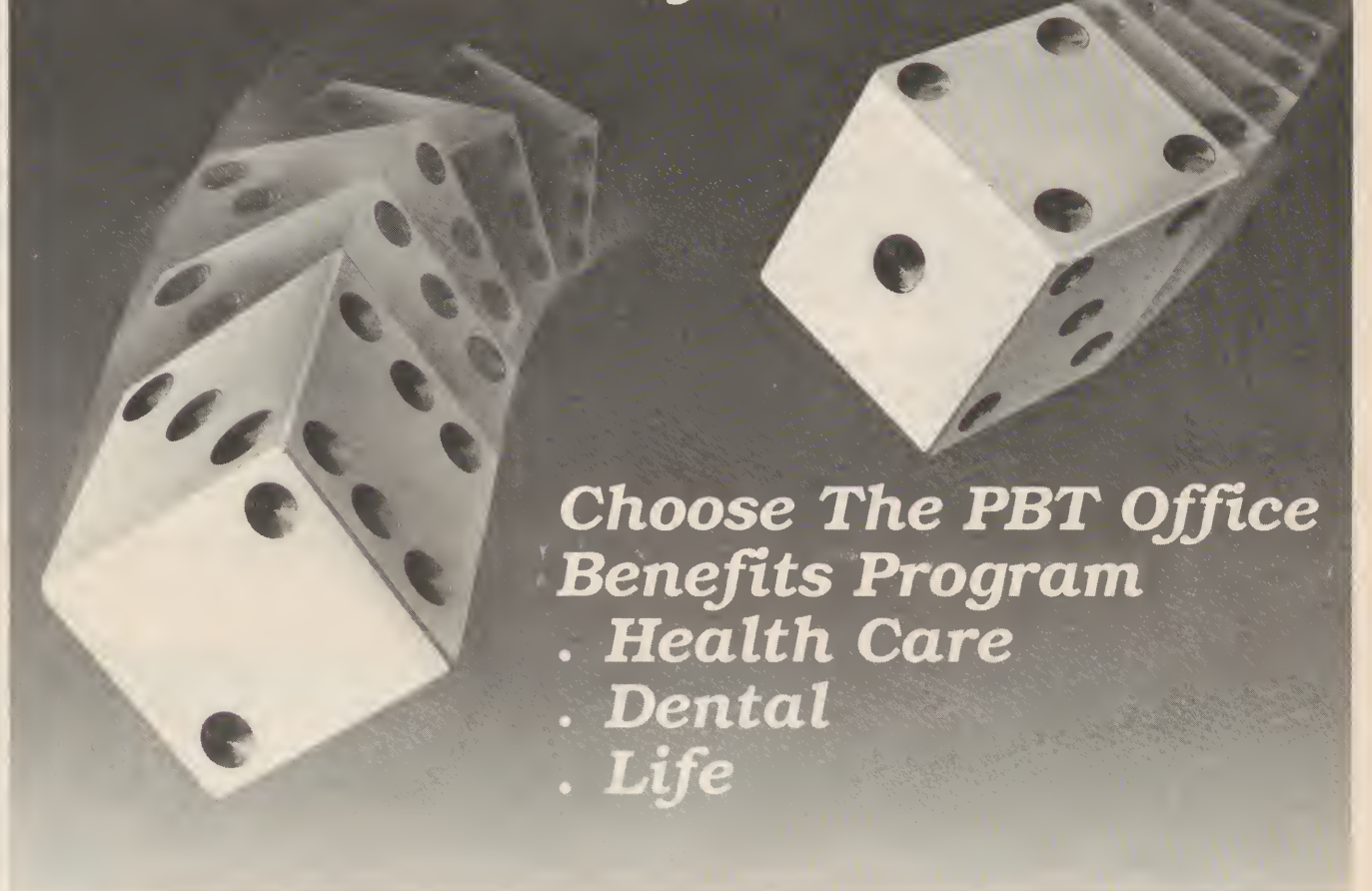
learn to manage it, so we're focusing on the clinic." Billings said the PHO expects to expand HMO services to other employee groups in early 1995.

"Everything is moving toward capitation. We needed to have an entity to do it. The hospital couldn't do it alone, and neither could the physicians," Sullivan said.

Fulfilling another goal of the managed care strategic plan, the Quincy Medical Group will move into a new \$9.2-million, 90,000-square-foot medical facility late this month, Sullivan said.

"Managed care has finally come to Quincy under an organized structure," Billings concluded. ■

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EDITORIAL

Investing in our future

The problems surrounding emerging democracy around the world underscore how far democracy has come in our country. The system of decision making by the majority is used not only by government but by organizations as well. That democratic process was at work during ISMS' recent Annual Meeting.

In reference committees, your delegates debated such issues as gun control, health care reform and physician profiling. Then during the House of Delegates meeting, delegates debated the issues again before voting on which resolutions would become policy and what that exact policy would be.

A critical issue considered by delegates was whether to increase ISMS dues. Your delegates did not make the decision capriciously. They asked many questions and explored many options. They heard that all ISMS budgets have been judiciously developed and controlled, that independent auditors have given ISMS a clean bill of financial health, that a three-year dues plan had been stretched over three additional years, that nondues revenues have helped allow ISMS to operate without an increase for six years and that permanent reserves have been used and must be replaced.

After hearing compelling reasons for a dues increase, your delegates concluded that ISMS' belt has been tightened as much as possible and that for the first

time in six years, an increase is critical. They voted to provide ISMS with the funds necessary to replenish permanent reserves, maintain core programs and develop new ones to help our members manage the changing health care marketplace.

The exact amount of that increase, \$149, breaks down to 41¢ per day. Those dollars will be spent on invaluable investments. They will fund the Washington Presence program, so that we will have greater influence on federal legislation. They will support efforts to achieve physician antitrust relief and tort reform. They will finance a feasibility study to determine how ISMS should be positioned to best serve members. And they will help develop a broad range of marketplace services to help you better compete and retain your autonomy in this environment of rapidly accelerating medical care integration.

The health care environment was different six years ago. Today, we're dealing with upheaval and a potential drastic change in the way health care is delivered. The question is, Will we manage or be managed by the financiers of medical care? The only answer is that we must manage change, and to do that, we need resources. To remain strong, we must have a strong financial base, and we must remain united. Years from now, when we look back at what this increase provided, we will have proof that our dues dollars were well-invested.

PRESIDENT'S LETTER

How far you go in life depends on how much you enjoy the trip

Alan M. Roman, MD



There is the story of a construction worker who approached the reception desk in a doctor's office. The receptionist asked him why he was there. "I have shingles," he said. She took down his name and address, asked for his insurance card and told him to have a seat. Thirty minutes later, a nurse came out and asked him what he had. "Shingles," he replied. She took his height, his weight and his blood pressure, had him take off his clothes and put him in an examining room. The doctor came in and asked him what he had. He said, "Shingles." The doctor asked, "Where?" He replied, "Outside in the truck. Where do you want them?"

In my new role as your president, I have the privilege and responsibility of communicating with you and of making sure you understand what I am trying to say. One of these responsibilities is to write a president's perspective twice each month. With the unenviable task of following in the footsteps of your presidents before me, most recently Dr. Traugott, I humbly accept this great honor and acknowledge its opportunities.

The Latin word for communication, "communico," means share. The Latin root "commune" means held in common. It is better to ask some of the questions than know all the answers. As your president, I will earnestly do my best to share both with you.

Communication is more than simply sending a message. It is creating shared meaning and understanding – swiftly, articulately and

precisely. The easiest relationship for me is with the 18,000 members of our Society. The hardest, and the one I treasure most, is the one with you, the individual member.

Discovery, as you know, consists of looking at the same thing as everyone else and seeing something different. I sincerely hope you will communicate with me from time to time and share your ideas and your concerns.

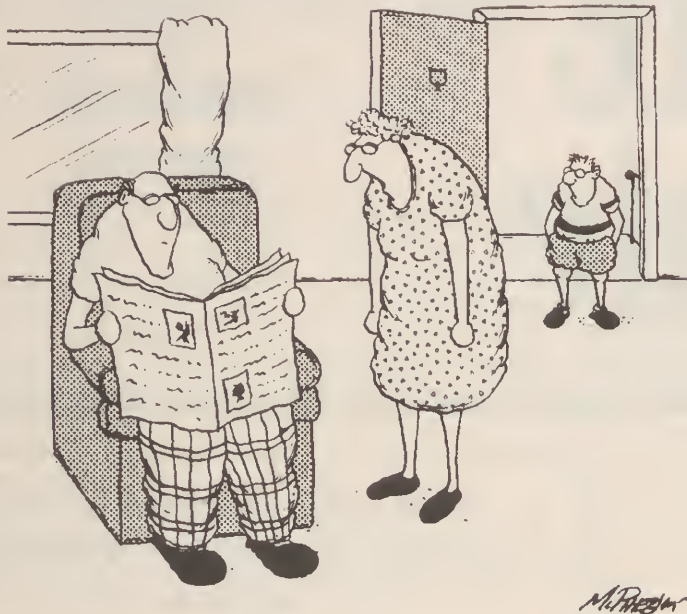
This year will be a pivotal year for our Society. I'm grateful for the privilege and opportunity to serve as your president. I eagerly anticipate representing your concerns and will provide visible, strong, aggressive and vocal leadership. When you are swimming for your life, you don't need a partner who only knows the dog paddle.

In return, I ask for a favor from each and every one of you: Think about being strong in peace of mind, think only of the best, work for the best and expect the best. With this attitude, we will successfully manage change and make every seeming problem an opportunity. Do not focus on how far away you are from feeling satisfied

but rather first reflect on how far we've come.

The path we must take is clear; the choice is ours to make. We all belong to the same profession. We have a responsibility to one another and to the future of medicine. *Your* involvement is critical to the future success of this organization. Your Society needs your support, your colleagues need your support, your patients need your support, and so, too, does your president. Your suggestions, criticisms, understanding, encouragement and friendship are, as always, very much appreciated.

*I eagerly anticipate
 representing your
 concerns and
 will provide visible,
 strong, aggressive and
 vocal leadership.*



"Jerry, the Morrison kid is here. He wants to know if we offer a health plan in addition to the five bucks we're paying him to mow the lawn."

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GUEST EDITORIAL

Smokers dispute the facts, but they are still the facts

By Joan Beck

Reprinted by permission: Tribune Media Services.

"Shame, shame on you," several recent letters to me have shrilled, one of them signed "with disgust." There are envelopes with hand-drawn swastikas. Clippings of columns crayed with unprintable obscenities across them in red. Diatribes calling me a "sanctimonious do-gooder," one suggesting I'm a danger because I could provoke angry readers into having heart attacks.

This time, the enraging subject isn't abortion or gun control or corporal punishment – it's smoking. And the mail's new level of vehemence is a surprise, suggesting that perhaps many smokers now feel trapped by accumulating medical evidence about the dangers of tobacco and growing social disapproval of smoking.

But 46.3 million Americans still smoke, despite the risks to their health, despite rising taxes on cigarettes, despite the rapid enlargement of nonsmoking public zones, despite the fears they cause in those who love them. And sadly, the long, steady decline in the percentage of adults who smoke, which began in 1973, seems to have stopped three years ago for reasons that aren't yet clear.

So for hard-core smokers – especially those who have accused me of making up anti-smoking statistics – here's a quick list of facts. If you can read it all the way through while still inhaling, that should be one more evidence of nicotine's insidious addictive power.

The facts come from a two-part series in the *New England Journal of Medicine* on the human cost of tobacco use. It was written by physicians at the University of Colorado School of Medicine. (And don't keep accusing me of making up numbers until you've checked every one of their 114 references.)

- U.S. deaths attributed to smoking in 1990: 418,690. Almost one death in every five is due to a smoking-related illness.
- The leading cause of preventable death in the U.S. today: smoking.
- Number of deaths from cardiovascular disease attributable to smoking: almost 20 percent, a total of 179,820 in 1990.
- Deaths caused by environmental tobacco smoke: 53,000 annually.
- Cancer deaths caused by smoking: 151,322.
- Amount of lung cancer attributed to smoking: 85 percent.
- Other cancers associated with tobacco use: cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, uterine cervix, kidney, ureter and bladder.
- Number of deaths in 1990 from pulmonary diseases, such as pneumonia,

influenza, bronchitis, emphysema and chronic airway obstruction due to smoking: 84,475.

- Number of U.S. teenagers and younger children who smoke: 6 million.
- Increase in stillbirths and neonatal deaths among the babies of mothers who smoke: 33 percent.
- Number of new cases of asthma among children caused by mothers who smoke 10 or more cigarettes a day: 26,000 a year.
- Percentage of smokers who begin using cigarettes before age 21: 80 percent to 90 percent.
- Number of teenagers who start smoking every day: 3,000.
- Number of cigarettes teenagers smoke: 1.1 billion packs a year.
- Prevalence of smoking among the least educated Americans: 32 percent.
- Prevalence of smoking among the most educated Americans: 13.6 percent.
- Most frequent cause of cancer deaths among women: lung cancer, with an estimated 56,000 fatalities, compared to breast cancer with 46,000 deaths in 1993.
- Increased risks faced by women smokers: osteoporosis, reduced fertility, miscarriage, complications of pregnancy, strokes and fatal and nonfatal heart problems.
- Percentage of cataracts attributed to smoking: 20 percent.
- Annual health care cost of smoking: at least \$100 billion.
- Extra average medical costs for a smoker over a lifetime: \$6,000.
- Average financial cost to American society of smoking in 1990: at least \$2.59 per pack.
- Extra days of work smokers miss annually: 6.5 days more than nonsmokers.
- Cost of lost productivity due to smoking-linked illnesses and premature death: \$47 billion in 1990.
- Cost of lost productivity resulting from environmental tobacco smoke: \$8.6 billion annually.
- Fires caused by smoking materials in 1991: 187,000.
- Deaths in fires caused by cigarette smoking: 2,300 annually.
- U.S. corporation that made the most profit in 1992: Philip Morris.
- U.S. corporation with the largest advertising budget in 1989: Philip Morris.
- Number of cigarettes exported from the U.S. in 1991: 194 billion.
- Only consumer product sold legally in the U.S. that without doubt causes cancer when used as intended: cigarettes.
- Political contributions by the tobacco industry in 1992: \$2.5 million to political parties and \$2.2 million to House and Senate candidates.

Those with an urge to write obscenities all over this column should send it to a tobacco company, not to me.

LETTERS

Physician is in-air Good Samaritan

I read with interest the article about the Good Samaritan Act in the March 25, 1994, issue of *Illinois Medicine*. I have had several experiences in which I have offered help in emergencies. None, however, were as dramatic as the one I faced a month ago on a flight from Alaska.

When I walked onto the plane, I told the crew that I am a retired physician and that I was willing to help in any way. Just as we were about to exit U.S. airspace into Russia, I was asked to look at a first-class passenger who was having an acute reaction to caviar.

When I reached the man, he was red as a beet and itching all over. His condition rapidly turned into anaphylactic shock. I gave him 8 milligrams of chlorpheniramine orally from my own supply. The crew then informed me the plane had an emergency kit. Had I known an emergency kit was available, I would have given him diphenhydramine hydrochloride through an IV before the onset of shock. Notably, before I was allowed to use the kit, I had to prove to the captain that I was a physician with a current license. I had to search through my carry-on bag to find the folder containing my license.

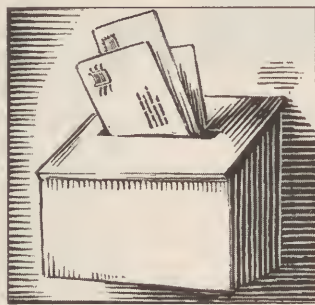
I could not obtain the patient's blood pressure, and I estimated his heart rate was 180 to 200. I quickly gave him IM epinephrine, even though the needles in the kit were very short. Gradually, he began to respond. His blood pressure started rising, his pulse came down, and he was perspiring less.

Meanwhile, the captain decided not to go further into Russian airspace with a sick passenger and returned to Anchorage. When we landed, the patient was almost normal. He was taken to a nearby hospital and received additional antihistamine to treat his hives, which disappeared within a few hours. He was kept in the emergency room for only about 30 minutes.

I found out later that my patient was a lawyer who was traveling with

another lawyer and their wives. As a retired physician, I do not have malpractice insurance.

This episode raises some questions and issues physicians should consider when volunteering to help in an emergency.



• In which country or state's jurisdiction did the event occur?

- Do you really want this liability exposure?
- If you are on an aircraft, have the flight crew give you the emergency kit at the onset of the emergency.
- Ask if there are other physicians or nurses onboard.
- Always carry proof that you are a licensed physician.
- Get permission to treat from the patient and or a family member and explain the limitations of treatment in an aircraft.

— Robert Hilker, MD
Hilton Head Island, S.C.

Watch for
Annual Meeting
coverage in the
next issue of
Illinois Medicine

ISMIE Update

Caps
amendment
approved

PAGE 9

The facts behind the medical-legal conflict

Physicians were once almost as active in legal matters as in medicine.

By Anna Chapman

During the early 1800s, more physicians held office as legislators and policy-makers in governmental bodies than they ever have since that time, said James Moore, PhD, chairman of the history department at the University of Oregon at Eugene. "Physicians were having an unprecedented impact on the fundamental infrastructure of American social policy."

Moore explained the history of the interaction between medicine and law at the annual Morris Fishbein, MD, dinner held April 5 by the Society of Medical History of Chicago.

Today's "medical-legal mess"

is not an "inevitable fate or grand conspiracy" against physicians. Instead, it developed from identifiable historical developments that occurred between 1835 and 1875, Moore said.

"Many early American physicians envisioned a post-Revolutionary society in which doctors, lawyers and the state would interact cooperatively for the benefit of the general commonwealth," he explained. These physicians believed they were helping administer justice, crafting the policies necessary to build a near-perfect society and maintaining the health of the young country, he said.

Physicians were "key coun-

selors throughout the nation, actively helping to shape laws and policies that we would regard as hardly medical at all," Moore continued. In this environment, medical jurisprudence thrived, he noted. Medical schools, which typically offered only four or five courses, regularly included core classes in medical jurisprudence.

This early physician involvement in medical jurisprudence affected American life in several important ways, Moore said. "American physicians dramatically altered attitudes toward mental illness during the first half of the 19th century." They convinced the public that men-

tal illness was more common than most people realized and that most forms of mental illness could be cured with professional treatment.

Working together, physicians and lawyers began to "break wills with ex post facto diagnoses of mental incompetence," proving that deceased individuals had

not been capable of properly distributing their possessions and declaring wills invalid.

PRE-CIVIL WAR medical-legalists also altered public attitudes about sexuality, Moore said. Physicians dispelled old English myths regarding the length of human gestation and conception. Other questions during that time were "whether a woman could become pregnant without experiencing orgasm and whether intercourse with a virgin could cure venereal disease."

Advances in toxicology and the detection of mineral-based poisons "permitted many doctors to be heroes on the witness stand, defending the innocent and convicting the guilty," Moore noted. Because of medical jurisprudence, society now had "scientific weapons" to prosecute the crime of poisoning, which was more common in the 19th century than might be expected, he said.

Because of the popular interest in toxicology, physicians involved in medical jurisprudence conducted much of the basic research that led to the medications of the 20th century, Moore said.

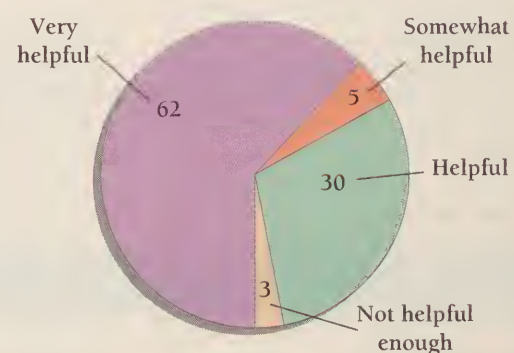
In the 1830s and 1840s, states were unwilling to grant any form of exclusive license to perform professional services, because of the public's opposition to monopolies. "Consequently, anyone who wished to practice medicine could do so," Moore said.

In addition, anyone could testify in court as a "healer,"

(Continued on page 9)

How policyholders rate the helpfulness of their ISMIE team

In percentage of respondents



Source: ISMIE Claims Monitoring Survey

MALPRACTICE ROUNDUP

Subjective standard preferred in failure-to-warn lawsuits

To prove proximate cause in a failure-to-warn malpractice suit involving elective surgery, the subjective standard is preferable to the objective standard, according to an Illinois appeals court ruling.

According to a summary of *Zalazar vs. Vercimak* reported in *Medical Malpractice Law & Strategy*, the plaintiff sued for injuries allegedly suffered during surgery to reduce the bags under her eyes. According to the patient, after the operation her eyes were droopy and her lower lids pulled away from her eyeballs. She said she would not have undergone surgery if the defendant physician had warned her about the risks and possible complications of the cosmetic procedure. The physician said he could not recall whether he had informed the patient of the risks prior to surgery.

Contending that the patient failed to present objective evidence that a reasonable person in her position would have refused surgery if he or she had known the risks and complications, the physician moved for and was granted a directed verdict. But the appeals court overturned the trial court's decision, agreeing with the plaintiff's argument that an objective standard for proving proximate cause is inappropriate for failure-to-warn suits involving elective cosmetic surgery.

The appeals court ruled the subjective standard is preferable to the "insurmountable" burden the objective standard poses for the plaintiff in cosmetic surgery cases. In addition, the court said that the "decision in cases such as this is too personal to turn on third-party testimony. Lacking a clear insight into the psychological makeup of the plaintiff and her personality, third-party or expert testimony as to the decision a reasonably pru-

dent person would make under similar circumstances would be of dubious value to the trier of fact, at best."

More patients suing for failure to diagnose breast cancer

Armed with new medical evidence that early detection can save lives and prevent the need for disfiguring mastectomies, breast cancer patients are suing physicians in increasing numbers for failing to diagnose the disease in its early stages.

According to the *Medical Liability Advisory Service* report, advances in breast cancer treatment have made it more difficult for doctors to claim patients would have died regardless of when detection occurred. And it says the stakes are high: Settlements typically range from \$50,000 to more than \$2 million.

Patients are filing suits claiming their physicians have not followed breast cancer screening guidelines recommended by such medical groups as the National Cancer Institute or their doctors should have been more thorough and aggressive in investigating a breast lump.

In conclusion, the report says physicians can help reduce their risk by following these steps:

- Proving a lump was investigated expeditiously. According to experts, a six-week delay is usually not significant; waiting six months to make a diagnosis is.
- Keeping accurate medical records. The point at which a woman first reports her symptoms is crucial and often a matter of dispute.
- Analyzing the nature of the cancer. If it is particularly virulent, for example, the physician can argue that deviation from the standard of care did not reduce life expectancy.

Caps amendment approved

STARK BILL: Subcommittee endorses a proposal limiting noneconomic awards. By Kathleen Furore

[WASHINGTON] With the help of the AMA's aggressive grass-roots lobbying efforts, an amendment proposing a \$350,000 cap on noneconomic damages was adopted during the late March markup session of the Ways and Means Health Subcommittee, chaired by U.S. Rep. Pete Stark (D-Calif). According to the AMA, which vigorously opposes other provisions of Stark's reform bill, the amendment's adoption represents a significant victory for physicians because it is the first time a proposal including caps on noneconomic damage awards has won support from a congressional committee.

"Given the liberal dominance of the Stark committee going into the markup, the chances of success were limited. However, we are pleased to report better-than-expected results," said AMA Executive Vice President James Todd, MD, in the AMA's *This Week*.

"Since 1985 – the year the first bill to address the issue [of caps] was introduced – the AMA has been working in D.C. to educate Congress and to seek

federal legislation to address problems related to professional liability insurance," said Scott Wilber, the AMA's director of congressional affairs in Washington. "Despite lingering areas of opposition, especially by the trial bar, many recognize the costs of professional liability insurance and defensive medicine are responsible for escalating health care

costs. No deals have been made, but there is widespread, bipartisan sympathy that some sort of federal action must be taken."

Wilber said the AMA is very satisfied with the solid support the \$350,000 caps amendment received from the bipartisan subcommittee despite Stark's objections. ISMS is also encouraged by the action, but the Society remains committed to enacting a \$250,000 cap in Illinois.

In related news, physicians in Illinois and throughout the country are contacting their federal lawmakers to urge them to support the Health Care Antitrust Improvements Act of 1993. This legislation, which was introduced in the U.S.

House and Senate, allows doctors to seek certificates of review from the U.S. attorney general for certain collaborative efforts.

AMA efforts also influenced adoption of two more amendments supported by physicians. The first directs the secretary of the Department of Health and Human Services to develop regulations banning insurance companies and managed care organizations from forbidding physicians to discuss treatment options with their patients – even when those patients aren't covered by a health plan. The other amendment deletes provisions that would have created a federal physician recertification program. ■



PBT claims examiners, like Becky Mayhew, average over 11 years of experience. All PBT claims are paid in Chicago.

Medical-legal conflict

(Continued from page 8)

Moore noted. "Testimony, therefore, began to undermine the scientifically oriented physicians who were making the real advances in medical jurisprudence and medicine itself."

Medical malpractice suits were virtually unknown in the United States before 1830, Moore said. In the previous decade, physicians had longed for malpractice suits to drive charlatans out of the medical field. Physicians got their wish when free-market policies were applied to medicine, Moore said. Malpractice suits became the only quality control available to the public, since there was no licensing or regulation. Then, in the 1840s, courts allowed more suits to come before the bar, he noted.

At the same time, medical advances helped convince Americans that they could improve their health. "It was not a coincidence that the first wave of malpractice indictments in the United States arose in the midst of the first wave of popular health reform," Moore said.

The most qualified physicians were threatened the most by litigation and were held most accountable because they took the most difficult cases and had financial resources, Moore said. In addition, they had developed written procedures and could be sued for deviations, he noted.

By the 1870s, medical schools began teaching students how to avoid involvement in law, rather than promoting medical-legal issues as they had done in the past, Moore said.

"The 1870s saw a few last-gasp efforts to save the old ideal of medical-legal interaction," he said. "Medical-legal societies formed but failed to bridge the gap between doctors and lawyers. They quickly disappeared or dwindled to private professional clubs.

"By the 1890s, medical jurisprudence was all but dead as a serious subject of study – or of practice – in American medicine," he added. ■

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MEDICAL MISSIONS

A caring doctor ministers to the poor

Risking health and personal finances, Dr. Myers delivers needed family medical care in the Mississippi Delta.

BY ANNA CHAPMAN

Early in his medical education, Ronald Myers, MD, knew that he wanted not only to help the poor, but also to treat those patients who most needed medical care. So when he completed his family practice residency, the Chicago-born ordained Baptist minister and jazz musician joined a practice in a poverty-stricken county in the Mississippi Delta. During his presentation at the fifth annual conference of the Illinois Rural Health Association March 23-24 in Effingham, Dr. Myers described his efforts to open and maintain the Tchula Family Health Center in an abandoned restaurant. The center is located in an area ravaged by extreme poverty, 70-percent unemployment and racism, he said.

Dr. Myers settled in Belzoni, in Humphries County, Miss., to fulfill the requirements of his National Health Service Corps scholarship. Recipients are required to practice several years in a designated medically underserved area. "I was excited about the program. I wanted to go where the need was the greatest."

Humphries County has the highest infant mortality rate in Mississippi, and Mississippi has the highest rate in the country, Dr. Myers noted. After having wondered why the rate was so high, Dr. Myers received one of his first doses of "Mississippi

reality" when he saw emergency room personnel refuse to treat poor, pregnant African-American women. "Some of the mothers were having babies in ambulances, some in carports, some in their homes. The first thing I said was, 'This hospital is going to have to change.' That's when I made my first set of enemies."

Despite the fact that the population of Humphries County was 70-percent African-American, the hospital was controlled by the white community, he said. He told the hospital officials that he would personally treat the pregnant women who were being turned away.

Dr. Myers said he was also amazed to see debilitating arthritis and carpal tunnel syndrome in patients in their early 20s. These workers were catfish industry employees who had never received adequate health care and were forced to work under intolerable safety conditions, he explained.

Early in his practice in Belzoni, several workers came to him, complaining of shortness of breath. Those patients, he discovered, had been exposed to large doses of carbon dioxide, used in the fish freezing process. Another patient was diagnosed with active tuberculosis.

Appalled at the lack of safety and hygiene measures, Dr. Myers complained to OSHA, the state health department and an organization representing the catfish industry. "I told them I don't ever want to see



Photos courtesy of Dr. Myers

MEDICAL MISSIONS

another patient come in here telling me he or she is short of breath from carbon dioxide.

"I found another sharp reality," Dr. Myers continued. "In rural Mississippi, the agencies that are supposed to help the public with health care issues are part of the problem." OSHA inspected the catfish plant and cited 11 federal safety violations, he said. The plant was fined only \$125.

"No wonder the people were so sick. The system did not have their best interest in mind."

TO IMPROVE THE SITUATION in Humphries County, Dr. Myers crusaded to educate the community about health care issues. His efforts led him beyond his medical training – to learning the local occupational hazards, working to change hospital policy and tackling the state legislature. He now serves as the medical adviser to the African-American caucus of 42 Mississippi legislators, who form one-quarter of the state legislature. "Now I have someone in my corner," he said.

While working to help Belzoni, Dr. Myers realized that nearby communities had no access to health care. In Tchula, about 20 miles away, in Holmes County, lived Eddie Carthan, who had been the town's first African-American mayor in the late 1970s. As mayor, Carthan was framed and imprisoned for a murder he did not commit. Dr. Myers had met Carthan when Carthan spoke about his ordeal at the University of Wisconsin, where Dr. Myers attended medical school.

With a population of 2,500, no hospital, no doctor and a surrounding community of 5,000 people, Tchula seemed the perfect place to open a practice, Dr. Myers said. He received the support and commitment of the town's mayor and prepared to open an office in an existing but vacant medical facility. Carthan was also dedicated to bringing health care to Tchula.

Dr. Myers' efforts were thwarted, however, when the district health officer told the mayor that Tchula didn't need and couldn't support a doctor – despite the community's lack of health care and Dr. Myers' willingness to work for minimal compensation. Consequently, the state health department refused to allow him to practice in the available county-owned clinic, he said.

But Dr. Myers was not deterred. He and Carthan renovated an abandoned restaurant in Tchula. "Eddie put up the initial \$7,000, and my wife and I drained our savings account, but we couldn't get any assistance from the state or federal government."

ON NOV. 22, 1989, the Tchula Family Health Center opened. Still committed to completing his scholarship requirement, Dr. Myers asked to serve part of his commitment in Tchula. The U.S. Public Health Service refused his request, he said, even though Belzoni had a hospital and five physicians, while Tchula had none. If scholarship recipients change their practices before they complete their service, they must remain in the same county, he explained.

So Dr. Myers began a routine of working nine-to-five, five days a week in Belzoni, then driving to Tchula and working in the clinic three hours each night. To raise enough money to keep the Tchula clinic open, Dr. Myers worked in the Belzoni emergency room each weekend and late some weeknights. "I was working about 110 hours a week," he said.

During that period in late 1989, a reporter from Mississippi's largest newspaper interviewed Dr. Myers. Although he expected only a short article – he asked the reporter to send a magnifying glass with it – the story made the front page, bearing the headline "Tchula has doctor despite government ruling."

Not long after that, a *New York Times* reporter visited the Tchula Family Health Center. On Feb. 12, 1990, Dr. Myers' story appeared on the front page of the *Times*. "I could not believe it. Everybody called. Charles Kuralt called. Connie Chung called. I found out how much competition there is between television networks. My wife and I were not prepared for this." Dr. Myers was interviewed by Chung and Ted Koppel and appeared on NBC's "Today" show.

Because of the national exposure, donations for the clinic began to arrive from across the country, he said. With the funds, Dr. Myers formed the Myers Foundation for Indigent Health Care and Community Development. Following the publicity, the Public Health Service reconsidered Dr. Myers' case and allowed him to complete his service in Tchula.

But the foundation did not receive enough money



No wonder the people were so sick. The system did not have their best interest in mind.

for Dr. Myers to alter his rigorous schedule. Overwhelmed by exhaustion, Dr. Myers became ill. After he broke five ribs from coughing, he was hospitalized for four weeks. He feared that if he couldn't continue as he had, the clinic would close.

Yet Dr. Myers said he had faith that God would protect the health care of Tchula. While he was in the hospital, his wife called him one day to say she had received a check – for \$25,000 – from Paul Newman. The clinic was saved.

Dr. Myers also raises funds for the foundation through his "Music for Medicine" jazz concert series. He recently released his first recording, "Doctor's Orders," which is available on compact disc and cassette. Proceeds from the concert series and sales of the recording go directly to the Myers Foundation, he said.

"Making a difference in rural health really goes back to the individual," Dr. Myers said. "You cannot legislate love, you cannot legislate caring, you cannot legislate sacrifice. That's on all of us individually."

"There's always going to be a need in rural areas for doctors and caring people," Dr. Myers continued. "There's always going to be a need for people to say, 'I'm going to commit my life to bringing health care to the Tchulas throughout Illinois, to the Tchulas throughout America.'"

For information about the concert series or to order a compact disc or cassette, write to the Myers Foundation, P.O. Box 637, Tchula, MS 39169.

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Patient care teams

(Continued from page 1)

tal prefers to fill the technician positions with individuals who have some type of medical background.

Administrative associates will help chart patients' conditions and medications and handle admissions and discharges. Support associates will deliver and collect meal trays. About 140 administrative and support associates will be hired. Lockwood noted that some current employees will be retrained to fill the new positions, eliminating the need for extensive layoffs.

The Illinois Nurses Association opposes filling RN slots with lesser-skilled, nonmedical professionals, according to Louise Shores, INA's executive administrator. "I don't have specific information on what is happening at Central DuPage Hospital, but in general, we're very concerned about replacing nurses with uncensored [assistant] workers and downsizing RN staffs. Over the past few years, we've seen many front-office, adminis-

trative positions added at hospitals. We think those systems should be cut before jobs involved in direct service delivery. It is inappropriate to replace RNs simply as a cost-cutting measure. We're concerned that doing so will lower and in some cases compromise the quality of patient care."

Shores cited studies conducted nearly 20 years ago — the last time nurses' assistants were widely employed — that indicated programs such as this actually can increase costs. "Studies showed it cost more money for RNs to train and supervise assistants, especially because there was such a high turnover in those areas. It's our position that this attempt to cut costs is probably futile. It has the potential to increase costs and also has ominous consequences in terms of quality of care."

But Michael Hoffman, MD, president of the Central DuPage medical staff and an ENT at the Glen Ellyn Clinic, said patient care teams will optimize care and cut costs dramatically.

"With the health care environment we live in, maintaining quality while reduc-

ing costs is an extremely important phenomenon," said Dr. Hoffman, a member of a committee overseeing the patient care team project. "We have to provide the same or better care in a less expensive environment. Team care is just one part of a quality improvement project throughout the entire hospital designed to reduce waste, provide better care and operate more efficiently."

THE HOSPITAL EXPECTS the program will save several million dollars per year, Lockwood added. "The typical way to reduce costs does nothing for quality. You just have fewer people doing the same amount of work. This approach allows us to have more people and still save millions of dollars. We're cutting some professional-level jobs and adding positions for multiskilled workers who can do many things for patients. And nurses will be freed from time-consuming [nonclinical] tasks and secretarial work so that they can do what they were professionally trained to do."

Dr. Hoffman stressed that models for

the teams were developed by nurses and other key staffers with input from physicians. "Physicians were concerned that quality not be sacrificed and that some system be built in to check and confirm that we aren't losing the quality of care we already have by implementing this new model."

A respiratory care committee will continue overseeing respiratory care, while the patient care technicians begin performing such tasks as helping postoperative patients breathe deeply to expand their lungs, Dr. Hoffman said. In addition, technicians who draw blood will be instructed by nurses and receive backup from an IV team. IV infections are "very, very low" at Central DuPage, and the infection rate will be monitored closely to ensure that quality of care doesn't suffer, he added.

Although nurses at Central DuPage were initially skeptical of the program, many now support the team-care concept, Lockwood said. "While some nurses still have a wait-and-see attitude, a lot of them have jumped on the bandwagon." ■

Tobacco industry

(Continued from page 1)

tain smokers' addictions. He cited as evidence a 1981 study written by a tobacco company executive that showed the lowest tar cigarettes have the highest nicotine concentrations. The study even described how the industry uses specific tobacco blends to achieve higher nicotine levels in low-tar cigarettes, Waxman said.

"Industry representatives have

appeared on national television and flatly said that they don't manipulate nicotine levels in cigarettes. This is not true," Waxman continued. "Mr. [Alexander] Spears' article proves that even the industry knows this."

Spears, who authored the study Waxman cited, is vice chairman and chief operating officer of Lorillard Tobacco Co. At a March hearing, he testified before Waxman's Subcommittee on Health and the Environment that tobacco

manufacturers do not manipulate nicotine levels in cigarettes, Waxman said.

UNDER INCREASING PRESSURE heightened by congressional hearings last month, the tobacco industry finally released a list of 559 chemicals used to manufacture cigarettes. According to information from the CDC provided by Waxman's office, those chemicals include nicotine sulphate, a toxic compound that can cause nausea, vomiting, mental confusion and convulsions after acute exposure; trichlorofluoromethane, which can induce rapid and irregular respiration, tremors and loss of consciousness following significant acute inhalation; and ammonia, which when inhaled in increasing concentrations can lead to coughing, sneezing, nasal discharge, bronchiolar damage, edema, hemorrhage and emphysema.

The tobacco industry was also criticized in the Surgeon General's report for devoting \$4 billion a year to advertising and promoting cigarettes to children and adolescents. In spite of the ban on broadcast advertising, cigarette and smokeless tobacco product manufacturers capture the lucrative youth market with billboard ads, sponsorship of sporting events and public entertainment, point-of-sale displays and distribution of specialty items, the report said.

"Cigarette advertising uses images rather than information to portray the attractiveness and function of smoking," the report said. "[It] appears to affect young people's perceptions of the pervasiveness, image and function of smoking."

The report also noted that such misperceptions "constitute psychosocial risk factors for the initiation of smoking" and that such advertising "appears to increase young people's risk of smoking."

Those findings are significant because evidence shows that the length of time people smoke and the amount of tobacco products they use are related to their incidence of related health problems such as lung cancer and cardiovascular disease, the report said. It also stated that the earlier the age at which individuals begin smoking, the more likely they are to use tobacco products heavily and to continue the habit into adulthood.

More than 3 million adolescents smoke cigarettes, more than 1 million adolescent males use smokeless tobacco and nearly

all young smokers first use tobacco products before graduation from high school — most by age 16, according to the report. "Preventing tobacco use among young people is therefore likely to affect both duration and intensity of total use of tobacco, potentially reducing long-term health consequences significantly," the report said.

Waxman's press conference, congressional hearings and the CDC report are part of growing momentum to regulate cigarettes as drugs because of the addictive

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*Industry representatives
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nature of nicotine, according to a report in *Morning Digest*, compiled by the publishers of the *White House Bulletin*.

Locally, a physician expressed mixed reactions to the increasing negative publicity about tobacco products. "If what they're saying about nicotine levels is true, I think it will cause greater harm to the public," said Joseph L. Murphy, MD, a Chicago physician who specializes in internal medicine and geriatrics and who prompted ISMS' policy calling for a smoking ban in open and closed stadiums. "But unfortunately, I don't think all of this information will have an impact on smoking consumers. After all, they're not afraid of the threat of lung cancer, stroke, emphysema or premature babies."

Dr. Murphy added, however, that the new findings will affect his approach with his patients regarding tobacco use. "This will stimulate me as a physician to work harder to dissuade my patients from smoking and to encourage the young people I treat not to start. It will make me place a higher priority on having educational discussions [about tobacco use] with my patients — to make that a prime consideration." ■

Drug review

(Continued from page 1)

tant task is to draw up plans for criteria that will guide the computer to identify the Medicaid cases that need to be sorted out," Dr. Johnson said. The criteria are being designed to select cases in which patients are at sufficient risk, he explained. "We don't want criteria that result in our identifying too many cases or too few cases."

In addition, the data base will contain complete drug and diagnostic data on all Medicaid recipients eligible for benefits. "We started with the premise that we don't want someone else setting up our program – that we don't want to use a canned program from a national organization or copy what other states have done. Most DUR programs are directed toward immediate cost-savings. They ask things like, Can we use a cheaper drug than what's being used? Cost savings will be one of the very desirable side effects. Our goal is to educate and foster cooperation between prescribing physicians and pharmacists in ways that will increase the quality of patient care."

To achieve that goal, the Illinois program will try to reduce drug therapy failures and drug-induced complications, which create the need for more costly physician or institutional remedial care services, according to IDPA. The areas required to be examined in the DUR process are underutilization, overutilization, iatrogenic effects/adverse reactions and drug therapy contraindicated by diagnosis.

its criteria and plugging in its data."

DUR programs like the one being implemented in Illinois should also help reduce risk, according to Morse. "The Medicaid system – and for that matter, the health care system in the private sector – promotes using different physicians

for different physical problems. Consequently, the majority of patients are being treated by multiple physicians. Our program is really a matter of coordinating care, of asking physicians, 'Are you aware of what the other doctors who are treating your patient are doing?'

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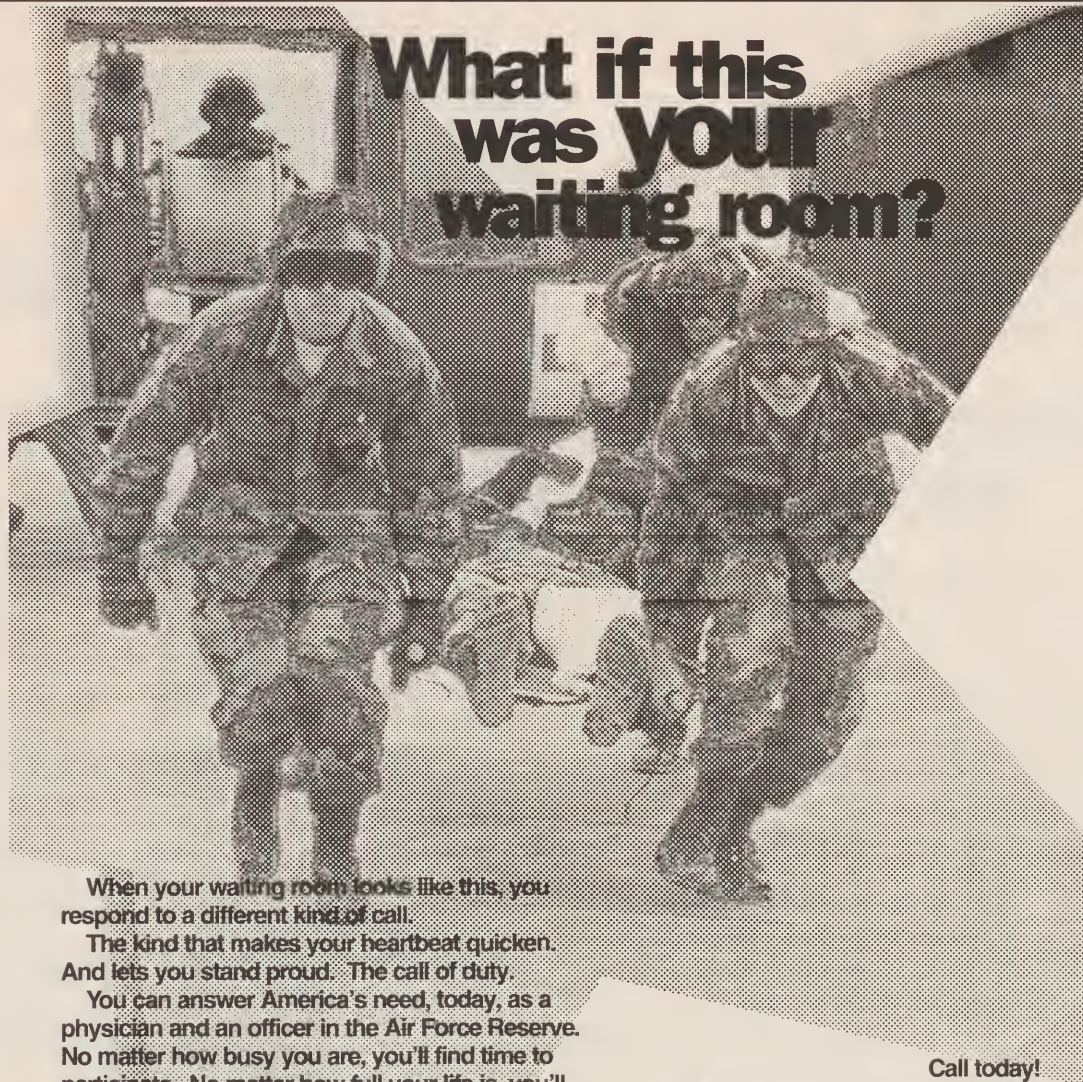
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THE STATE'S PROGRAM is not designed to intrude on physicians' or pharmacists' professional turf or to punish them for prescribing or dispensing medications in question, Dr. Johnson said. "We simply want to coordinate information each physician and pharmacist may have that the other doesn't know about," he explained. "There are no punishments unless we discover incidents of fraud and abuse." And even those would be referred for further review by the Surveillance Utilization Review program prior to any action, Dr. Johnson added. He also emphasized that the program in no way affects physicians' Medicaid reimbursements.

Lee Morse, chairman of PharMark Corp. – the licensor of the pharmaceutical outcome tracking technology to be used – addressed concerns that DUR may be perceived by some as nothing more than a PRO for drugs. "Some DUR systems have taken on second-guessing physicians' decisions. But our system isn't designed to bring a physician in and say, 'Hey, you ordered this. Explain why.' That kind of question is irrelevant to our objective, which is not to challenge the care administered but to make physicians aware of what a patient's other treating physicians and pharmacists are doing. It doesn't tell doctors how to get better results or how to choose and prescribe drugs; it absolutely does not mandate care."

PharMark's software identifies the risk of adverse outcomes based on the diseases treated and the medications prescribed, said Marvin Hazelwood, IDPA manager of pharmacy and ancillary services. However, the program is tailored by members of the DUR board to meet the needs of Illinois physicians, pharmacists and patients, he added. "The board ultimately controls how the software works by using



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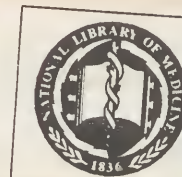


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ILS STATE MEDICAL SOCIETY • MAY 20 1994

NEW ISMS PRESIDENT

Alan M. Roman, MD, is congratulated on his installation by his wife, Lin, and children, Justin and Lindsay, during the Society's Annual Meeting last month. As president, Dr. Roman will travel throughout Illinois representing physicians and communicating doctors' concerns about health care reform and other issues.



Matt Ferguson

Governor pledges ongoing support for tort reform

CAPS: Edgar calls for physician input in the health care reform debate. By Kathleen Furore

[OAK BROOK] In an address to the ISMS House of Delegates on April 23, Gov. Jim Edgar called the legal system "out of control" and promised to continue fighting for caps on noneconomic damages as long as he holds office. He also solicited physician support and input in crafting and ultimately passing health care legislation in Illinois.

"The need for tort reform, caps and common sense is great. As long as I am governor, I will make [those issues] a priority. We can't achieve an affordable health care system if the legal system is out of control - if it is taking the resources you need to provide high-quality, affordable care," Edgar told the attentive delegates, who had welcomed him with a standing ovation.

"It takes more than just a governor; it takes a legislature that agrees with the same principles. This election is crucial to ensuring the changes in the legal system so desperately needed in the state.

ANNUAL MEETING WRAP-UP

"You're on the front lines day in and day out. With your help, we can come up with a system that will provide good health care at a reasonable cost," he added.

Stressing the importance of the November election and the need for "different faces in the General Assembly," Edgar outlined his platform for health care reform in Illinois. He cited an overhaul of the state's Medicaid system as vital to the state's fiscal health and the health of its poorer citizens. "Medicaid doesn't work. Costs are out-of-sight. It is being dictated by congressmen, bureaucrats and the federal government. We've tried before to provide new money to Medicaid, but we can't afford Medicaid as we know it in Illinois," he said, noting that costs have risen threefold in the last three decades.

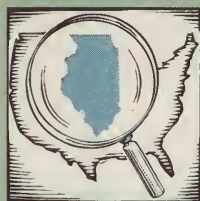
Edgar explained that his proposal calls for moving Medicaid toward a managed care system directed by physicians and other health care professionals and focused on preventive care and early intervention. The system

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Payers' record reviews pose confidentiality risks

CREDENTIALING: As health plans contract with physicians, new issues surface. By Anna Chapman

[CHICAGO] As part of the credentialing or recredentialing processes, some third-party payers are asking physicians for random nonplan patient medical records, according to ISMS general counsel Saul Morse. Physicians should not participate in this practice, Morse advised. Although physicians may be denied contracts with some managed care health plans if they refuse to submit to measures that breach physician-patient confidentiality, they could face legal consequences if they allow such reviews to occur, he noted.

Under the Illinois HMO Act, health plan administrators may inspect only the medical records of members, Morse said. The law states: "The HMO shall require each provider to maintain an active record for each enrollee who receives health care services.

This record shall be kept current, complete, legible and available to medical and administrative staff of the HMO."

Physicians who consent to random nonplan reviews of records are not only breaking their confidential relationship with their patients, but they are violating the Illinois Code of Civil Procedure, Morse said. In addition, physicians could face possible disciplinary action for unethical behavior, he noted. "If physicians are asked to consent to random medical record inspections, they should refuse.

"If the patient is covered as an insured of the plan requesting the records, in most instances an authorization or release will have been signed as part of the enrollment process authorizing patient records to be shared with the payer,"

(Continued on page 19)

ISMS and other medical societies study PHOs

MANAGED CARE: Physician organizations play a major role in the success of PHOs. By Anna Chapman

[CHICAGO] Results of a new study of physician hospital organizations reveal that the most successful PHOs include a strong physician organization, trust between physicians and hospital administrators, the participation of primary care physicians and sophisticated management systems, according to ISMS analysts. Sponsored by ISMS, the Indiana State Medical Association, the Michigan State Medical Society and the AMA, the study is a response to physi-

cians' growing interest in PHOs, said Thomas Gorey, president of Physician Hospital Organizations Inc., the consulting firm that conducted the study.

"There has been a lot of discussion about PHOs, but not a lot of good, solid information. It has mostly been anecdotal and conceptual," Gorey explained. "The medical societies wanted a case-study approach targeting specific PHOs."

The study was based on data

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Projects aimed at combating HIV and AIDS in Cook County

TREATMENT: Initiatives include a new medical center and a study of the disease in women. By Rick Paszkiet

[CHICAGO] Two new initiatives are under way in Cook County to treat AIDS and slow its spread: the construction of a major HIV/AIDS medical center and a study examining the progression of HIV in women.

The Cook County Bureau of Health Services and Rush-Presbyterian-St. Luke's Medical Center announced that they will build and operate a new facility to treat patients with HIV, AIDS and other related communicable diseases. The medical center will be a referral site for primary care providers who are currently delivering community-based care to people with HIV and AIDS, Rush officials said.

In addition to providing specialized outpatient care, the center will conduct clinical research and prevention activities, Rush officials said. The facility, which will be constructed with federal and private funds, will be called the Cook County/Rush Health Center: A Partnership for Communicable Disease Prevention, Care and Research, according to Rush officials.

"We have a severe public health crisis in this country with the spread of HIV [and] AIDS, yet our public health system isn't equipped to handle it," said Christie Hefner, chairman of the center's Project Board, which oversees fund raising for the facility. "The center will be the first of its kind in the country and is designed to be a prototype for national efforts to manage HIV/AIDS and other communicable diseases."

Pending approval by the Cook County Board, the \$30-million facility will be built on county-owned land on the Westside Medical Campus, said Richard Phelan, board president.

Also in the works is a study about the progression of HIV disease in women. The three-year study of 250 HIV-infected women will be funded by a \$5-million grant from the National Institutes of Health, according to Cook County officials. The research is important because women represent the fastest growing segment of new AIDS cases, officials said.

"The study will help define HIV women by identifying certain AIDS-related illnesses and non-HIV-related diseases in HIV-infected women," said Mardge Cohen, MD, director of Cook County Hospital's Women and Children HIV Program. "This is the first study that will

examine the natural history and course of certain gynecologic conditions to determine whether HIV-infected women have a higher incidence of such infections and their response to treatment."

The four hospitals participating in the study – Cook County, Rush, Northwestern Memorial Hospital and the University of Illinois Hospital and Clinics – provide primary care services to more than 90 percent of the HIV-infected women in Chicago. ■

New date set for ISMS, Kane County forum

The upcoming health care reform forum sponsored by ISMS and the Kane County Medical Society, in conjunction with U.S. Rep. J. Dennis Hastert (R-Batavia), has been rescheduled for June 13. The daylong meeting will be held at the Pheasant Run Convention Center and Resort in St. Charles. Hastert is a member of the House Energy and Commerce Committee, which has jurisdiction over reform legislation.

Highlights of the program include presentations on the status of the reform process in Washington, case studies depicting failures and successes in the current system and a panel discussion featuring health care experts, including physicians.

For more information, contact the ISMS governmental affairs division at (312) 782-1654 or (800) 782-ISMS. ■



GAIL ROSSEAU, MD (right), a neurosurgeon at Columbus Hospital in Chicago, explains the findings on a patient's radiology tests to Khalilah Gates, 16, who wants to be a physician. Gates spent the day with Dr. Rosseau on April 28 for Take Our Daughters to Work Day.

Study shows high-fat foods OK with moderate alcohol

[HOUSTON] There's good news for beef lovers who are concerned about cholesterol: Researchers at Houston's DeBakey Heart Center of Baylor College of Medicine said drinking moderate amounts of alcohol when eating the high-fat meat can increase high-density, or good, lipoproteins without escalating low-density, or bad, lipoproteins. That finding is significant, since the LDLs usually increase when high-fat foods are consumed without alcohol, according to Henry Pownall, PhD, professor of medicine

and molecular physiology at Baylor.

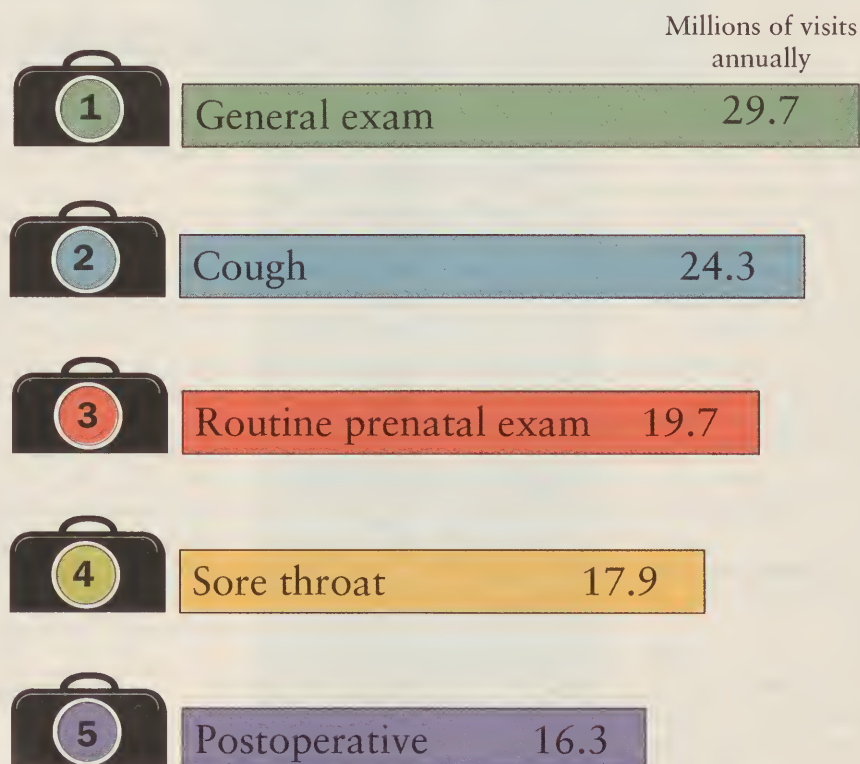
"The alcohol boosts an enzyme that increases the body's efficiency in metabolizing the fat," Pownall explained. "The extra amount of enzyme means more HDL is made than LDL."

Baylor researchers are conducting a three-year study to test their theory that alcohol – not the fruit or grain used to produce it, as other studies on red wine and dietary fat have shown – is directly responsible for the positive effect on dietary fat, Pownall said. "Once we know how it works, we can begin looking for a substance that can do the same job, maybe even more efficiently, without the intoxicating effects. We know alcohol has a negative effect on triglycerides and blood pressure and can cause liver and kidney damage. However, if there is a positive relationship between moderate alcohol consumption and the body's ability to metabolize fat into HDL rather than LDL, we need to know that, too."

Other studies conducted by the DeBakey Heart Center have examined the differences in blood alcohol levels between people who drink while eating and those who drink on an empty stomach. Research showed that drinking 14 ounces of alcohol on an empty stomach rapidly increases blood alcohol levels. But although consuming food with alcohol delays the increase by up to two hours, it also slows the body's return to a normal blood alcohol level, the studies revealed. "You were told not to drink on an empty stomach, and that is sound advice. Drinking without food affects you faster. Drinking with food affects you longer," Pownall added. ■

PHYSICIAN FACTS

Top 5 reasons for visiting a physician



Source: U.S. Centers for Disease Control and Prevention, 1991 data

Beware of billing scam

The Blackhawk Area Medical Association is warning physicians about a recent scam uncovered in Rockford. Physicians' offices in the area have received fraudulent invoices for medical supplies from the Medical Discount Center in Las Vegas. Doctors who receive a phony bill from this company for supplies they did not order should contact the Nevada attorney general's office at 401 S. Third St., Suite 500, Las Vegas, NV 89158; or call (702) 486-4320. ■

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City, suburban physicians make house calls to elderly

VOLUNTEER CARE: Doctors find mental and physical deterioration in seniors who can no longer care for themselves. By Anna Chapman

[CHICAGO] Two programs operating in the city and the suburbs are helping some abused and neglected seniors receive medical care. Physicians participating in Methodist Hospital of Chicago's Elderly in Distress program and Suburban Hospital's house call program in Hinsdale evaluate and treat the homebound elderly, often with little compensation. All the physicians volunteer their time on a rotating basis, accept Medicaid and Medicare assignment and treat patients who lack insurance, according to EID director Sharon Gottlieb and Suburban program coordinator David Miller, RN.

"Doctors have a responsibility to take care of not just healthy people who come in for checkups, but people who really need health care," said Salomon Dayan, MD, EID medical director and president of Health First Clinics in Chicago. Many of the housebound patients he treats are destitute or nearly so, he said.

Gottlieb, a social worker, started the EID program in 1986, when it served mainly the North Side. She recruited several physicians, including Dr. Dayan, who asked Health First physicians to participate. After receiving referrals from various city and state agencies serving the elderly, the program expanded to cover the entire city, Gottlieb said.

"This is my heart and soul," said Gottlieb, who received the Governor's Award for Unique Achievement in the Area of Aging in 1990 and the Retirement Research Foundation of Chicago's Exemplary Commitment to the Elderly Award in 1993. "It has been more successful than I had dreamed."

About 20 primary care physicians participate in EID, covering a large portion of the city, Dr. Dayan said. They, along with visiting nurses and social workers, respond to referrals from the various agencies. The physicians' primary responsibility is to determine patients' safety in their environment, their need for medical intervention and the most appropriate place for them to live. "We provide a complete geriatric assessment," he noted.

"By the time we get to them, they have significant problems, things they have neglected," said Phillip Skoczelas, MD, a four-year EID volunteer. Such problems could include conditions ranging from hypertension and diabetes to organic brain syndrome and paranoia, he added. The patients often live in squalor, unable to clean themselves or their houses, he said, noting that they may also be victims of abuse by family members.

Under Illinois law, after evaluation by a physician, elderly patients unable to care for themselves may be placed in the hospital for up to 72 hours, even against their will, Dr. Skoczelas said. To fully assess the need for hospitalization, physicians must rely on relatives, neighbors and social workers for information about patients' fitness to care for themselves. "I used to be naive and believe [the patients'] stories," he said, noting that they often say that they visit a doctor regularly and that they will go the next day. Or they may invent excuses why the doctor should not see them, because they are afraid of what an examination might reveal, he said. "Peo-

ple want to hold onto every thread of independence to the last second."

MODELED AFTER the EID program, the Suburban Hospital house call program is composed of five physicians who each take weekly call to visit homebound patients over age 65, Miller said. Participating physicians receive three to four calls per week and are available 24 hours

a day to visit most suburbs, he added. During the house calls, they assess the patients' overall health, and they may prescribe medication and perform tests that are processed at the hospital. The charge is \$40 for a home visit.

"People say they can't believe doctors come to the house," said Roland Borassi, MD, a Suburban internist who has also participated in the EID program.

"I'm a busy doctor, but I feel as though it's part of my practice.

"There are a lot of underserved [seniors] in the community who are not accessing medical care," Dr. Borassi continued. "It's a reality in the United States that the underserved need the most care."

Some house call programs have not worked previously because doctors did not know what they were getting into, Dr. Borassi explained. "You're not going into nice suburban homes. They're very bad from a hygienic point of view." Even though the house looks fine on the outside, the people inside might be malnourished or physically or mentally ill, and they need to be taken care of, he said. ■

Blue Cross Blue Shield



REPORT

FOR *Illinois Physicians*

CRYOSURGERY OF THE PROSTATE

BACKGROUND: Cryosurgery techniques gained popularity in the 1960's. This technology was first applied to treatment of the prostate in the late 1960's. The procedure itself involves insertion of a hollow probe into diseased tissue and application of a cold solution through the probe which causes freezing of surrounding tissue. Tissue death results from: intracellular dehydration, toxic electrolyte concentrations, crystallization with membrane rupture, denaturalization of protein, thermic shock, vascular stasis.

In the late 1970's, techniques for application of the freezing solution including utilization of liquid nitrogen were improved. Both benign and malignant conditions of the prostate were being treated. With this increased use of cryosurgery of the prostate, a number of complications were identified, which included: urinary tract infections, delayed separation of necrotic material with subsequent urinary tract obstruction, freeze injuries to surrounding tissues including bladder, ureter and rectum.

A phenomenon observed in a limited number of patients who have been treated with cryosurgery consists of a reduction in size and number of metastatic lesions at the time of treatment of the primary cancer. Autoimmune mechanisms have been thought to be the cause of this phenomenon and research to identify the exact immune response trigger continues.

Although survival rates for patients treated with cryosurgery at every stage of disease are equal to survival rates for patients treated with radical prostatectomy or external beam radiation, the rate of complications from freeze damage to associated structures has made cryosurgery unacceptable as a treatment alternative for benign conditions. To reduce the complications, a variety of methods including open surgical approaches to allow more accurate probe placement and procedures utilizing ultra sound guidance of probe placement have been investigated. Ultrasound can measure the freeze zone as it propagates through tissue, thereby providing a method to avoid freeze damage to adjacent structures. Ultrasound guidance of cryosurgery has been utilized since the 1980's to treat hepatic tumors and has been applied to prostate cancer since 1991. Current mechanisms also include utilization of multiple probes (up to 7) to better control freeze damage to surrounding structures. Published reports to date describing ultrasound and cryosurgery to treat prostate cancer cover only 3 to 6 months of post-operative experience.

AUTHORITY: The American Urological Association in August of 1993, indicated in a position statement that Cryoablation (Cryosurgery) for treatment of prostate carcinoma is considered to be investigational. No other national technology review organization has as yet issued any statement concerning Cryoablation (Cryosurgery) for prostate cancer. The Blue Cross Association through its technology evaluation and coverage program has this issue under review, but no date for publication of the Association's evaluation has been set. A panel of urologists at the recent (February 1994) Midwest Clinical Conference concurred with the Urological Association's opinion that cryosurgery remains investigative.

RECOMMENDATION: Based upon the policy of the American Urological Association, the opinion of local urologists and upon published literature providing only limited post-operative experience for utilization of ultrasound and cryosurgery, this procedure continues to be considered as investigative by Blue Cross Blue Shield of Illinois.

Medical savings account bill passes House

LEGISLATION: Bills addressing reform and other health care issues hang on as the session advances.

By Anna Chapman

[SPRINGFIELD] A bill allowing portable and tax-free medical savings accounts passed the Illinois House of Representatives May 6. The Medical Care Savings Account Act is one of several health system reform bills the House and Senate are considering this session.

Sponsored by Rep. David McAfee (D-Summit), H.B. 4086 authorizes employ-



ers to establish medical care savings accounts for their employees. Identical bills H.B. 2895 and H.B. 3700, introduced by Reps. Ann Hughes (R-McHenry) and Mary Lou Cowlshaw (R-

Naperville), did not emerge from the House Rules Committee.

Under the provisions of H.B. 4086, participating employers designate account administrators, such as banks, insurance companies, certified public accountants or attorneys, to withdraw money from the savings accounts to pay for employees' medical care. Individuals may use account funds to pay medical expenses or to purchase a health insurance policy, according to a House analysis of the bill.

Employer contributions to the accounts are Illinois tax-free to the employee if they are used to pay medical expenses, according to the bill. The legislation also enables employers who contribute to a medical care savings account program to issue interest-free loans to employees whose medical expenses exceed the amount in their account. However, if employees assume such a loan, they must agree to repay the advance from future employer contributions or in a lump sum if they leave the company, according to the analysis.

Employees may use money from their accounts for purposes other than medical care. However, those withdrawals are taxed as Illinois income and assessed a 10-percent penalty. In addition, if employees change jobs, the accounts may be transferred, provided their new employer also participates in a medical savings account program.

ISMS supports H.B. 4086. In fact, at the Society's Annual Meeting in April, the ISMS House of Delegates approved a resolution promoting the concept of medical retirement or savings accounts related to health care reform and mandating an investigation of further refinements.

Acupuncture

Amending the Alcoholism and Other Drug Abuse and Dependency Act, H.B. 4108 directs the Illinois Department of Alcoholism and Substance Abuse to fund a pilot program to "implement and evaluate the use of auricular acupuncture in the detoxification and rehabilitation of substance abusers." The bill, which is sponsored by Rep. Lou Jones (D-Chicago), passed the House May 5.

The bill defines auricular acupuncture as substance abuse treatment by "insertion of needles at a specified combination of points on the surface of the outer ear." The House approved an ISMS-prompted amendment to prohibit the practice of auricular acupuncture except by MDs and DOs.

In addition, the pilot program must be developed and conducted in a "scientifically valid manner" to determine the efficacy of acupuncture in treating substance abusers, according to the amendment. The pilot is to be conducted by MDs and DOs and must meet federal standards for protecting human research subjects.

Under the bill, the DASA director must report results of the pilot program to the governor and General Assembly within six months of its completion on Jan. 1, 1998.

ISMS does not oppose the bill as amended, since it does not call for the licensure of nonphysician acupuncturists.

Direct reimbursement for nurses

A bill allowing direct Medicaid reimbursement for nurse practitioners resurfaced. H.B. 3885, sponsored by Rep. Carol Ronen (D-Chicago), had been committed to the House Rules Committee but was brought back for reconsideration. At press time, the bill was held on the House calendar order of second reading.

ISMS opposes H.B. 3885 because direct reimbursement could lead to independent practice by nurses. Current Illinois law stipulates that nurse practitioners must practice under physician supervision. The Society promotes health care delivery using a team concept, whereby doctors and nurses work cooperatively. However, ISMS is concerned that quality of care issues could arise if nurses were permitted to practice without physician supervision.

Expanded practice

A bill that would have expanded optometrists' scope of practice stalled in the Senate. ISMS opposed S.B. 1207, sponsored by Sen. Frank Watson (R-Carlyle), because it would have permitted optometrists to diagnose and treat eye disease — functions that only physicians can carry out under Illinois law. According to ophthalmologists, the bill would have posed potentially serious health risks to patients. S.B. 1207 failed to receive enough votes on the floor to pass and was held on postponed consideration.

Licensing of tattoo artists

Acting on House of Delegates policy, ISMS prompted the introduction of a bill requiring the state to license and regulate tattoo artists. H.B. 3911, sponsored by Rep. Ray Frias (D-Chicago), received 83 votes and passed the House May 5. The bill creates the Tattoo Artist License Act and requires tattoo artists to comply with minimum education, sanitation and operational standards developed by the Illinois Department of Professional Regulation. Physicians are exempt from the act.

Following debate and negotiations regarding the bill, an ISMS-prompted amendment passed mandating that artists explain to their clients that the decision to be tattooed is a permanent one. Tattoo artists must also detail the application procedure and provide possible tissue reactions. The length of time artists must keep their clients' records was changed from two years to 10 years. In addition, the amendment removed a provision requiring physicians to supervise the application of facial tattoos.

Uniform claim forms

A bill that requires health care providers to use uniform claim and billing forms advanced from the Senate. Sponsored by Sen. Robert Madigan (R-Lincoln), S.B. 1479 amends the Illinois Insurance Code by mandating that providers use a universal claim form for billing insurers beginning Jan. 1, 1996. The code already authorizes the director of the Illinois Department of Insurance to "prescribe by rule ... insurance claim and billing forms that the director determines will provide for uniformity and simplicity in insurance claims handling," according to the bill. ISMS House of Delegates policy supports the use of a uniform health insurance claim form, and the Society does not oppose the measure. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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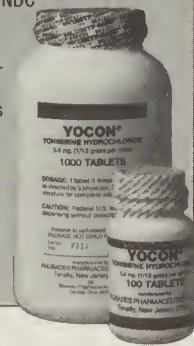
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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Doctors can be architects of managed care

Changes in the medical marketplace allow physicians to reassert control over patient care. By Anna Chapman

Physicians do not have to be victims of managed care. In fact, in many markets, managed care is driven by physicians, according to Carol Emmott, PhD, president and chief executive officer of Health Direction Inc., the California consulting firm conducting a feasibility study of Illinois' medical marketplace on behalf of ISMS.

"You're the glue, the element that will cement the system," Emmott told Illinois physicians at an April 23 educational seminar held during the ISMS Annual Meeting. To develop positive managed care opportunities, physicians need to work together, she said. Doctors must "set their own standards and protocols in a business relationship and create more explicit clinical relationships among colleagues."

Such relationships can enhance physician influence over clinical care, added John Ray, who is president of the Clearwater Group and will serve as a study consultant. "Managed care aimed at improving the health of a population really turns on the quality of the patient care [physicians] deliver." Physicians should make medical decisions without being forced to check with payers for permission to perform specific procedures, he noted.

"Managed care is a process, not a thing," Ray continued. Accepting managed care as a process, however, requires physicians to alter their thinking about the practice of medicine, he noted. Physicians who ignore the move toward managed care may see that opportunities are passing them by, he explained.

To improve patients' health and save money, managed care organizations must allow physicians to have more oversight of clinical care and economic issues, according to Ray. By removing third-party payers from the system, physicians will gain greater control over patient care, he said. Without those payers, physicians can also determine how income generated by the organization is distributed. "This is a radical notion from a voluntary medical staff perspective. But that's what organized prepaid medical groups do."

The availability of capital is also critical to physicians' success in forming organizations, Emmott noted. "Building the infrastructure required to deliver care in a more organized fashion will have significant capital requirements," she explained. Although most physicians do not accrue capital in their practices, there

are many partnership opportunities and other options that physicians can use to obtain the necessary resources, she noted.

Organizational opportunities for physicians range from "very loose IPAs to staff model HMOs," Ray said. As an example,

he cited management service organizations, which are separate corporations formed by physicians and hospitals to perform administrative functions. In a basic MSO, physicians retain their tangible assets and office personnel. Typically, physicians pay a management fee to the MSO, which provides services such as managed care contracting and administration.

In hospital-driven managed care, the hospital employs physicians to provide patient care and pays them a salary, Ray said. "The hospital entity usually retains substantial ability to take independent strategic and business actions."

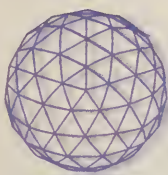
A new managed care entity – the physician equity model – has been successful

in Southern California, Ray said. A prime example is the Mullikin medical group, a multispecialty group owned and operated by physicians. It also owns a small hospital. Groups like Mullikin either run their own hospital or contract with other hospitals at an aggressive daily rate, Ray said. "The physicians keep 100 percent of the money they save on the hospital side. These are not physicians who are thinking small."



Emmott

MANAGED CARE



BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

The ethics of execution

As this issue of *Illinois Medicine* went to press, John Wayne Gacy was executed by lethal injection. Death penalty cases raise many ethical issues, and this instance was no exception.

For physicians, a primary issue is whether doctors should play any role in executions. The Hippocratic Oath includes the words *Primum non nocere*, "First, do no harm." This standard forms the ethical foundation for physicians practicing in Illinois and the nation.

ISMS takes no position on the merits of the death penalty itself. But we do believe it is unethical and unprofessional for a physician to participate in a state-ordered execution. For such unethical and unprofessional conduct, physicians are subject to review by the Medical Disciplinary Board under the state's Medical Practice Act. And we're not alone in our beliefs. The AMA, the World Medical Association and other medical organizations support the same ideals.

Legislatively, we have made some progress in this area. During the 1992 session, the state legislature passed an ISMS-supported bill eliminating the requirement that two physicians serve as witnesses at state-ordered executions. However, a doctor must still pronounce the death of an executed inmate. The Illinois Department of Corrections, the Illinois attorney general's office and several state's attorneys fought the attempt

to eliminate this pronouncement-of-death requirement, calling it a "back-door attempt to abolish the Illinois death penalty law."

During the weeks preceding Gacy's execution, four physicians filed a complaint seeking to ban the participation of a licensed physician in the proceedings. "Physician participation in executions is fundamentally inconsistent with the healing role of the medical profession and poses a direct threat to the relationship between physicians and the public, whom they serve," stated the complaint.

ISMS defines physician participation to be any assistance in preparing, conducting or witnessing the execution process, as well as medical pronouncement of death after the execution. A specific exception is providing succor, solace and relief of suffering to a condemned person awaiting execution.

In addition to the pronouncement problem, physician participation remains shrouded in secrecy through confidentiality provisions in the law. This allows participation without the opportunity for professional peer review of the ethics of that action.

As physicians, we are sworn to use our professional skill and judgment for healing, not helping with state executions. Just as law enforcement officers are expected not to break the law in pursuing their professional duties, physicians should not be expected to act in opposition to our medical oath.

PRESIDENT'S LETTER

An easy task becomes difficult when done with reluctance

Alan M. Roman, MD



Communicating with members is the very best part of being your president.

An optimist and a pessimist pooled their resources and started a business together. Sales were fantastic, and after the first three months, the optimist was elated. "What a great start," he said. "Customers love our product, and sales are increasing every week." "Sure," replied the pessimist, "if things keep going like this, we'll have to order more inventory."

Communicating with members is the very best part of being your president. Sometimes optimistic, sometimes pessimistic, members are always informative and enlightening and display a variety of attitudes. The recently concluded Annual Meeting at Oak Brook Hills provided me an opportunity to hear from physician leaders who represent doctors in almost every county of this state.

What I heard were very mixed messages – sometimes positive, sometimes negative, oftentimes upbeat and occasionally sad. There was, nevertheless, a consistent theme: Enough is enough. Anger and frustration are giving rise to despair born of a sense of helplessness at trying to influence a system going out of control and a sense that members are going it alone. Based on what I hear, there is no sense that organized medicine is getting the job done. Well, in surveys, time and again members have told us that malpractice reform tops the list, and your society is working hard toward its goal of substantive reform (caps) by 1995. At the same time, the health care reform debate and the growth and expansion of managed care programs are demanding increasing amounts of members' time from a day that consists of only 24 hours and is crammed with increasing responsibilities.

The health care reform debate, for me, has been discouraging. From the original secret working task force to the almost 1,400-page bill, the process has been flawed. The issues are too complex. The media are not asking the right questions. The public doesn't understand the issues. Doctors have not connected solidly with

patients on the issues.

With respect to managed care, not all members are aware of what they need to learn. The key ingredients for success have been well-described, but many physicians have not spent the time necessary to learn about managed care. Yet rapidly and relentlessly, the framework for this new delivery system is being assembled right now – in Chicago and the suburbs, and in varying degrees around the state. In less than a year, the landscape will look entirely different. Doctors presently are experiencing fear, but they have not yet felt the pain. Most doctors tell me that their patient visits and income have held relatively steady.

All of us at one time or another have shared some or all of these doubts, concerns and feelings. The tide comes in and goes out, swelling for our members one day and against them the next. There is no way individual members can understand what is happening. They need support and input from their society. They need to know that they are not alone and that others sympathize and agree with them. Your society and leaders are working tirelessly and feverishly on your behalf. We have developed a strategic plan aimed at achieving a political, legislative and educational role in health care reform at the state level, and through the Washington Presence program, at the federal level as well. Through the program Health Reform: Taking Charge of Change, your society is involving physicians and the public in the health care reform debate. The upcoming membership briefings are designed to help answer many of the yet unresolved questions you have. The ISMS feasibility study will evaluate the Illinois market and the attitude and needs, as well as the receptivity, of our society membership. The ability and willingness of physicians to self-regulate will be the key to any managed care entity.

An optimist thinks the glass is half-full; a pessimist thinks the

(Continued on page 19)



"The same people who told me the stork brought me are making me stand here for lying."

GUEST EDITORIAL

Physicians want more than a good seat on the train

By Terry Meriden, MD

I am one of many health care providers who are glad to see a more open reform discussion than the one surrounded with secrecy a year ago. But while we are delighted to see important reforms introduced to help uninsured and underprivileged citizens, I am concerned about some of the ideas and ideologies generated in the president's reform proposal. The premise that only government can fix this problem and that doctors, hospitals and insurance companies have created the current difficulties is totally false and beyond comprehension.

All recent polls show that most Americans have good insurance coverage and are happy with their doctor and hospital care. To blame physicians for the rising cost of health care is like blaming the police for crime. The increase in health care costs is caused by many factors, one of which is our aging population. In 1960, there were 10 children for every person 65 or older; in 1990, the ratio was 2 to 1.

Forty percent of health care funds are spent during the last six months of a person's life. The increasing use of new and expensive drugs and the explosion of modern technology for diagnosis and therapy are contributing to these costs. Rehabilitation, disability and nursing home care create additional demand. Moreover, the spread of AIDS and other behavioral diseases – such as smoking, drinking, drugs and violence – as well as the rising expectations of a public that wants miracle cures, have contributed to rising health care costs. In addition, the enormous cost of the current liability system adds to increasing expenses, including \$50 billion a year wasted on defensive medicine.

Europe and Canada have often been cited as shining examples in the health care debate. I practiced in England's socialized medical system for several years and I know firsthand the pitfalls of such a system. Although I paid only about \$50 a year for an unlimited malpractice policy, the care I was forced to deliver was unconscionable. Physicians had to deny intensive care unit admissions for patients who had heart attacks or lung failure, solely because they were over 60. Other patients had to wait two years or more for elective surgical procedures like hernia repair. Those decisions were dictated by none other than Big Brother, the government, which enforced global budgets and rationing and perpetuated bureaucratic red tape.

Thousands of physicians of my generation left England and flocked to the United States to practice. Luckily, we still have the best medical care in the world here, despite the system's pitfalls. And the system is working for most of us; only certain flaws require remedies. However, to correct these flaws, we do

not have to create new bureaucratic agencies that dictate what may and may not be done. In the president's Health Security Act, the word mandatory is used 24 times, the word prohibit is used 51 times, penalty is mentioned 59 times and limited appears 239 times.

Physicians recognize that the Clintons are trying to give everyone the same health package, but this is America, where people live in different houses, have different jobs, drive different cars, take different vacations and, yes, have different health care coverage. People should be free to buy whatever package they choose. Under the president's proposal, if individuals want to buy medical care denied to them under the rationing constraints of a health alliance, patients and physicians could face fines and imprisonment.

Further, I question whether the new system will save money. In 1965, the pundits and bureaucrats estimated that Medicare would cost \$9.5 billion per year by 1990. They were off by only \$55 billion. Even the Congressional Budget Office was politely skeptical about the money-saving claims associated with the president's plan. The CBO report was filled with phrases such as "The evidence is insufficient, and it remains uncertain and unclear."

The natural advocates for patients are physicians, not alliances, insurance companies, lawyers or politicians. We cannot and will not support health reform that leads to severe and cruel cuts in Medicare funding and penalizes the elderly to the tune of \$80 billion a year. We also cannot endorse reform that fails to protect patients' privacy because of the use of a centralized data bank and that features global budgets and entrenched bureaucracy.

Moreover, we cannot support reform that abolishes patients' fundamental rights to choose their own doctor without economic penalty or that allows only a limited choice from a list of permissible options. In addition, we will not support reform that fails to promote tort reform.

Under health system reform, physicians do not intend to become petty bureaucrats or civil servants in exchange for a good seat on the train. That train is headed over a cliff, and it's our responsibility to turn it around. Most physicians have worked hard throughout their careers – often at least 80 hours a week – to make a difference in the lives of their patients.

I hope the Clintons will use their enthusiasm and influence to work with physicians to achieve a health care system that will still be the finest in the world.

Dr. Meriden is an endocrinologist in Peoria.

LETTERS

An excursion into prehistory

I was bemused by the guest editorial "Drive-through deliveries" in your March 25 issue. If Ms. Gordon considers herself a dinosaur, then I suggest an excursion into prehistory, at least chalcolithic, when women with normal obstetrical deliveries were routinely hospitalized for 10 days. I did say 10.

The first seven days were occupied with bed rest (with bathroom privileges for the sturdier souls). A wheelchair was provided on the eighth day, walking indulged on the ninth day, and discharge allowed on the 10th. This was provided, of course, that the new mother was unfortunate enough to develop a thrombus in a femoral vein with massive edema of a lower extremity resulting from her enforced immobilization of the previous week; it carried the impressive name of phlegmasia alba dolens. Not rarely, that thrombus became an embolus to the pulmonary vein, causing sudden death. But those were the hazards of childbirth in that enlightened era. Besides, it didn't cost much in those

halcyon days. Further, a woman was only a housewife anyway, and not really an important element in our great society.

Was there bonding? Well, we didn't make it easy for them. There was a central nursery, and every four hours, out marched a cadre of nurses with their precious cargo to be held for 30 minutes by the new mama. The word "bonding" had not yet entered Webster's *Unabridged*.

Could there be nursing? Well, that complicated the routine. It was possible, but it had to be fought for. First, it entailed a private room or a two-bed accommodation – no less. Second, it had to be done in a corner with the mother facing the wall, so that her shame would not be manifest. It was called the Cornelian Corner after the Roman matron Cornelia who nursed her child in that fashion out of modesty.

Am I really relating prehistory? No, this was Chicago at the pre-mid-20th century in an outstanding teaching, academic and patient-oriented establishment with a national reputation. Health care reform will always be in the eye of the beholder.

– Alex Tulskey, MD
Chicago

GAIL COOK, a senior professional liability analyst who works out of ISMS' Springfield office, is the most recent employee recognition award winner. Her territory includes Sangamon, Madison and St. Clair counties, as well as other counties throughout the middle of the state.

Carla Sommerfeld



ISMIE holds
elections for
Board of
Governors

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ISMIE Update

ISMIE
underscores
ongoing
commitment to
policyholders

PAGE 9

Altering records can damage more than a legal defense

Physicians may lose a lawsuit, their insurance and possibly even their license if they change medical records. By Kathleen Furore

Altering medical records can seriously affect – and potentially even end – a physician's career. That is the strong message delivered by malpractice attorneys and risk management experts, who said in no uncertain terms that physicians should never change notations in a patient's chart to try to strengthen their defense in a malpractice suit.

"We have had many medically defensible cases that went down the tubes because of alterations made to try to make the cases look even better," said Harold Jensen, MD, chairman

of the ISMIE Board of Governors. "It's human nature to want to put your best face forward. But physicians have done some naive, unsophisticated things under the pressure and emotion of the moment, and a jury assumes records wouldn't have been changed if everything was OK. If someone demonstrates your records were altered, there is the presumption of guilt. Then where are you? It's almost impossible to defend."

That fact was echoed by Joe Camarra, a malpractice defense attorney at Cassidy Schade & Gloor in Chicago: "Altering

medical records is a huge problem. You like to go into a courtroom with credibility for you and your client, but if a jury suspects you're not being honest, the aura of respect you have as a physician becomes eroded. The presumption that you're a competent medical practitioner is rebutted, and it gives the plaintiff's attorney an incredible edge and ammunition with which to attack you on issues not related to the patient's care but to your credibility."

Reduced credibility is just one of the serious ramifications of altering medical records, accord-

ing to Bob Austin, a malpractice defense attorney with Chicago's Lord, Bissell & Brook. Changing medical records also limits the defense's ability to call expert witnesses to the stand. "It becomes virtually impossible to retain an expert. If you don't tell [the expert you planned to call] that you made changes, you're guilty of withholding important information. And if you do, it raises the same questions for the expert witness that it raises for the jury: Why and under what circumstances were the records altered? In addition, if you, as an attorney, are aware of a record

change and it isn't revealed to the plaintiff's attorney or the expert, you know the expert could be giving testimony that could be false. It puts the lawyer in a difficult position ethically."

In fact, the situation becomes so serious that Austin typically recommends settling a case in which records have been changed, he said. "The physician could have done the right thing, and other defenses could be available," he said. "But if there have been alterations, the jury just won't accept what the defense has to say."

For physicians who make even the most well-intentioned changes, the risk also extends far beyond the courtroom: It can affect their ability to obtain malpractice coverage and even cause problems with the Illinois Department of Professional Regulation's Medical Disciplinary Board, according to Dr. Jensen.

"When our Physician Review and Evaluation Panel finds that

(Continued on page 11)

MALPRACTICE ROUNDUP

Theophylline problems lead to malpractice suits

Theophylline – a bronchodilator described as the most frequently prescribed drug for asthma and chronic obstructive pulmonary disease – poses significant clinical problems because of its increased use in treating respiratory diseases, according to an article in the *Malpractice Reporter*. Physicians can avoid theophylline injuries in their patients and related liability suits by learning more about the pharmacological, toxicological and clinical uses of the drug, as well as by closely monitoring its clinical use, according to the author of the article, James O'Donnell, MD, a consultant pharmacologist and pharmacist and faculty member at the Rush Medical College in Chicago.

Dr. O'Donnell cited several malpractice cases involving theophylline. In one, a Chicago jury awarded \$78 million to the family of a four-year-old for injuries that followed the child's toxic reaction to the drug. Liability in the case was based on the drug manufacturer's failure to provide updated dosage information and on the failure of physicians to monitor the theophylline level in the child's blood, he said.

Dr. O'Donnell explained that the drug's effectiveness and toxicity are related to its serum level in patients' blood. The major causes of theophylline toxicity are patient and/or physician dosing errors and other patient conditions or medications that reduce the drug's clearance, he said. Physicians must monitor patients' blood levels and look for signs of toxicity to avoid overdose, drug interactions and convulsions, since an effective dose is so close to a toxic dose, Dr. O'Donnell said. In addition, he questioned the continued heavy use of theophylline because of its potential toxicity and the availability of less toxic alternatives.

To avoid injury and liability, Dr. O'Donnell recommended closer monitoring of clinical use of the drug, frequent blood level monitoring at appropriate intervals, clearer and more effective product labeling and increased physician awareness about possible drug interactions. Those actions "can only result in safer and more efficacious use of this drug," he said.

Dr. O'Donnell also cited opinions about the drug expressed by colleagues at a 1990 American Trial Lawyers Product Alert press conference. One pharmacologist called for more vigilant blood level monitoring – especially during flu season –

and for physicians to learn more about how viral diseases, flu and fever can inhibit metabolism of the drug. Dr. O'Donnell also quoted Howard Zeitz, MD, associate professor of medicine/immunology at Rush, who stated that "blood levels should be monitored at initiation of therapy, when symptoms present, on dosage adjustment and [on a routine basis] to ensure therapeutic and nontoxic levels [are] maintained. Patients stabilized on one brand of theophylline should not be switched to another generic source."

Patient wins suit based on religious convictions

A Jehovah's Witness who received a blood transfusion against his oral and written wishes was awarded \$500,000 by a New York jury, according to a report in *Medical Malpractice Law & Strategy*. In *Sargeant vs. Beekman Downtown Hospital*, the plaintiff – whose religious beliefs prevented him from receiving blood transfusions – was admitted to the hospital with internal bleeding and low blood counts. During treatment, the patient was given a blood transfusion, which he later compared with rape.

Although the defense claimed that the patient never told his physicians about his religious affiliation and that he failed to complete the forms necessary to refuse blood, the jury awarded the plaintiff \$350,000 for violation of his religious beliefs and \$150,000 for his claim that he feared contracting a disease.

A summary of the case stated, "[The suit] is particularly interesting in that it put a value on the violation of the religious convictions of the plaintiff." The report also noted that the jury's decision was influenced by testimony from an expert on Jehovah's Witnesses and the hospital's written policy stating that it advocates using blood and that "it might be better if any Jehovah's Witness that came to the facility be directed to seek treatment elsewhere." The policy was obtained during discovery.

According to the defense, which has filed posttrial motions, an unusual aspect of the case was the court's decision to send it to the jury on a battery charge. "The plaintiff even admitted he couldn't prove there was an intent to be offensive," said defense attorney Sean F.X. Dugan.

ISMIE underscores ongoing commitment to policyholders

SERVICES: ISMIE will continue the Clinic Option program, loss-free discounts and the fight for tort reform.
By Kathleen Furore

[OAK BROOK] During an April 24 address to the ISMS House of Delegates, Harold Jensen, MD, chairman of the ISMIE Board of Governors, highlighted

ANNUAL MEETING WRAP-UP

the company's accomplishments over the past year and changes for the 1994-95 policy year, stressing ISMIE's goal of placing policyholders first.

"We have spent the past 12 months as committed as ever to offering the finest professional liability insurance and unsurpassed service. We continue to strive to excel each day, because service has no history. We are judged on how we performed for you - today."

That "unsurpassed service" includes a variety of programs and products designed for ISMIE insureds, according to Dr. Jensen. Specifically, he cited the loss-free discount program, which recognizes policyholders' excellent loss-prevention efforts, and the Clinic Option, which offers premium savings to physician policyholders practicing in groups of five or more.

"I am pleased to report to you today that, once again, our policyholders have voiced strong support for our loss-free discount program," Dr. Jensen said. "More than 75 percent of policyholders qualified for a discount of from 3 percent to 10 percent [for the 1994-95 policy year]. Those who qualify reap the rewards of their efforts through valuable premium savings. This year, nearly 3,000 policyholders received a 10 percent discount - a testament not only to their risk management skills, but to their loyalty to ISMIE. The larger the discount, the longer they have remained loss-free with us."

ISMIE's innovative Clinic Option will again be available for policyholders, he said. "This offers the potential for premium savings of up to 28 percent, recognizing the built-in peer review and risk management that group practice provides," he added, noting that the program has variable policy limits tailored to the specific needs of each participating group. "In 1993, we added 29 groups to the ISMIE Clinic Option - an increase of 150 percent over 1992. As more and more physicians learn of these excellent benefits, we expect many others to utilize this program."

Dr. Jensen also outlined negative trends in the medical liability marketplace that forced the Board of Governors to authorize a 15-percent premium increase for the 1994-95 policy year. It is only the second premium increase ISMIE has levied in eight years. "I am not going to sugarcoat things for you," he told the audience. "I want you to understand the factors that led us to this difficult decision."

Among those factors are rising indemnity payments and increasing frequency and severity of claims, he said. In addition, claims with the most serious allegations of injury have increased 150 percent since 1986; the number of claims

reported annually has jumped from 1,300 in 1986 to 2,800 in 1993; and the average indemnity payment made on behalf of ISMIE insureds has skyrocketed to almost \$350,000, up from a 1988

(Continued on page 11)



Matt Ferguson

During the ISMIE luncheon at the Annual Meeting, Risk Management Committee Chairman Jere Freidheim, MD (left), and Board of Governors Chairman Harold Jensen, MD, celebrate the company's accomplishments over the past year. In the upcoming policy year, ISMIE will continue to provide policyholders with a wide array of programs as a part of Physician-First Service.

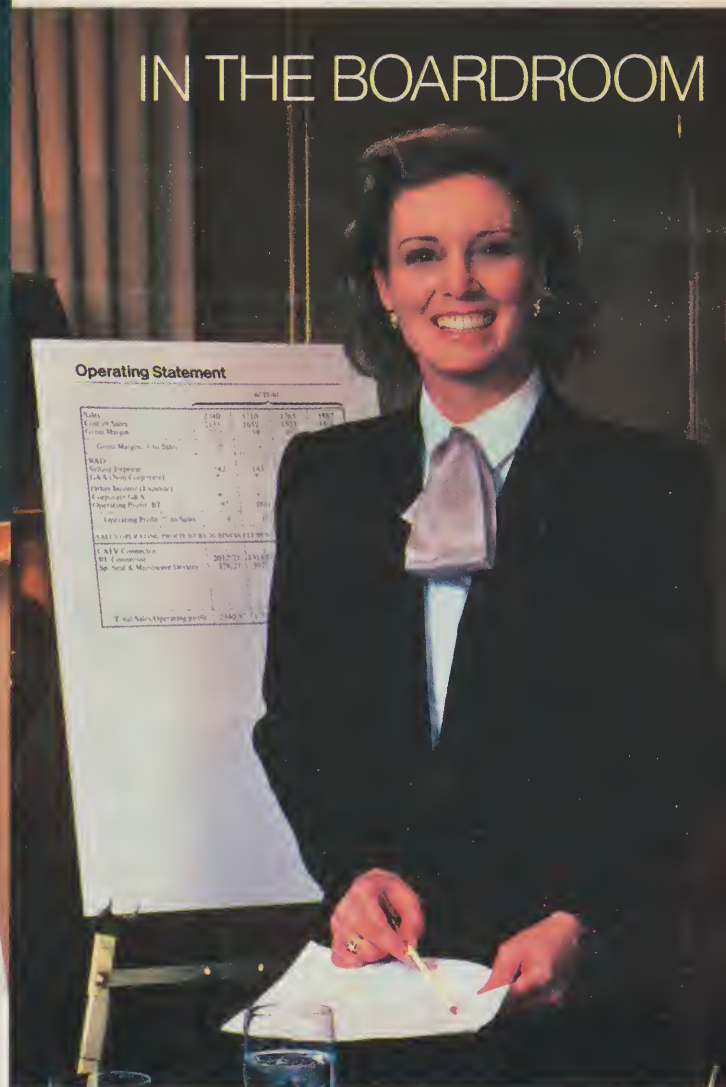
Seizures controlled, thoughts clear, smiles bright



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Generally avoids hirsutism^{2,3}

Avoids gingival hyperplasia^{2,3}



Tegretol 
carbamazepine USP

...because after seizure control, there's a lot of living to do!

ciba

Tegretol is indicated as first-line monotherapy for children 6 years of age or older and adults. The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea, and vomiting. To minimize the possibility of such reactions, therapy should be initiated at the lowest possible dose. As with all anticonvulsant therapy, periodic hematologic evaluations are recommended at the physician's discretion. Although reports of transient or persistent decreased platelet or white blood cell counts are not uncommon in association with the use of Tegretol, the vast majority of cases of leukopenia have not progressed to the more serious conditions of aplastic anemia or agranulocytosis. Please see complete Prescribing Information and references on next pages.

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References:

- Smith OB, Mattson RH, Cramer JA, et al. Results of a nationwide Veterans Administration cooperative study comparing the efficacy and toxicity of carbamazepine, phenobarbital, phenytoin, and primidone. *Epilepsia*. 1987;28(suppl 3):S50-S58.
- Mattson RH, Cramer JA, Collins JF, et al. Comparison of carbamazepine, phenobarbital, phenytoin, and primidone in partial and secondarily generalized tonic-clonic seizures. *N Engl J Med*. 1985;313:145-151.
- Herranz JL, Armijo JA, Arteaga R. Clinical side effects of phenobarbital, primidone, phenytoin, carbamazepine, and valproate during monotherapy in children. *Epilepsia*. 1988;29:794-804.

Tegretol®

carbamazepine USP

Chewable Tablets of 100 mg - red-speckled, pink
Tablets of 200 mg - pink
Suspension of 100 mg/5 ml

Prescribing Information

WARNING

APLASTIC ANEMIA AND AGRANULOCYTOSIS HAVE BEEN REPORTED IN ASSOCIATION WITH THE USE OF TEGRETOL. DATA FROM A POPULATION-BASEO CASE CONTROL STUDY DEMONSTRATE THAT THE RISK OF DEVELOPING THESE REACTIONS IS 5-8 TIMES GREATER THAN IN THE GENERAL POPULATION, HOWEVER, THE OVERALL RISK OF THESE REACTIONS IN THE UNTREATED GENERAL POPULATION IS LOW. APPROXIMATELY SIX PATIENTS PER ONE MILLION POPULATION PER YEAR FOR AGRANULOCYTOSIS AND TWO PATIENTS PER ONE MILLION POPULATION PER YEAR FOR APLASTIC ANEMIA.

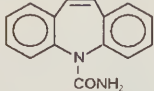
ALTHOUGH REPORTS OF TRANSIENT OR PERSISTENT OCECREASEO PLATELET OR WHITE BLOOO CELL COUNTS ARE NOT UNCOMMON IN ASSOCIATION WITH THE USE OF TEGRETOL, DATA ARE NOT AVAILABLE TO ESTIMATE ACCURATELY THEIR INCIOENCE OR OUTCOME. HOWEVER, THE VAST MAJORITY OF THE CASES OF LEUKOPENIA HAVE NOT PROGRESSED TO THE MORE SERIOUS CONDITIONS OF APLASTIC ANEMIA OR AGRANULOCYTOSIS.

BECAUSE OF THE VERY LOW INCIOENCE OF AGRANULOCYTOSIS AND APLASTIC ANEMIA, THE VAST MAJORITY OF MINOR HEMATOLOGIC CHANGES OBSERVED IN MONITORING OF PATIENTS ON TEGRETOL ARE UNLIKELY TO SIGNAL THE OCCURRENCE OF EITHER ABNORMALITY. NONETHELESS, COMPLETE PRETREATMENT HEMATOLOGICAL TESTING SHOULD BE OBTAINED AS A BASELINE. IF A PATIENT IN THE COURSE OF TREATMENT EXHIBITS LOW OR OCECREASEO WHITE BLOOO CELL OR PLATELET COUNTS, THE PATIENT SHOULD BE MONITORED CLOSELY. DISCONTINUATION OF THE DRUG SHOULD BE CONSIDERED IF ANY EVIDENCE OF SIGNIFICANT BONE MARROW DEPRESSION OEVELOPS.

Before prescribing Tegretol, the physician should be thoroughly familiar with the details of this prescribing information, particularly regarding use with other drugs, especially those which accentuate toxicity potential.

DESCRIPTION

Tegretol, carbamazepine USP, is an anticonvulsant and specific analgesic for trigeminal neuralgia, available for oral administration as chewable tablets of 100 mg, tablets of 200 mg, and as a suspension of 100 mg/5 ml (teaspoon). Its chemical name is 5*H*-dibenz[b,f]azepine-5-carboxamide, and its structural formula is:



Carbamazepine USP is a white to off-white powder, practically insoluble in water and soluble in alcohol and in acetone. Its molecular weight is 236.27.

Inactive Ingredients. Tablets: Colloidal silicon dioxide, D & C Red No. 30 Aluminum Lake (chewable tablets only), FO&C Red No. 40 (200-mg tablets only), flavoring (chewable tablets only), gelatin, glycerin, magnesium stearate, sodium starch glycolate (chewable tablets only), starch, stearic acid, and sucrose (chewable tablets only). Suspension: Citric acid, FO&C Yellow No.6, flavoring, polymer, potassium sorbate, propylene glycol, purified water, sorbitol, sucrose, and xanthan gum.

CLINICAL PHARMACOLOGY

In controlled clinical trials, Tegretol has been shown to be effective in the treatment of psychomotor and grand mal seizures, as well as trigeminal neuralgia.

It has demonstrated anticonvulsant properties in rats and mice with electrically and chemically induced seizures. It appears to act by reducing polysynaptic responses and blocking the post-tetanic potentiation. Tegretol greatly reduces or abolishes pain induced by stimulation of the infraorbital nerve in cats and rats. It depresses thalamic potential and bulbar and polysynaptic reflexes, including the linguomandibular reflex in cats. Tegretol is chemically unrelated to other anticonvulsants or other drugs used to control the pain of trigeminal neuralgia. The mechanism of action remains unknown.

In clinical studies both suspension and conventional tablet delivered equivalent amounts of drug to the systemic circulation. However, the suspension was absorbed somewhat faster than the tablet. Following a b.i.d. dosage regimen, the suspension has higher peak levels and lower trough levels than those obtained from the tablet formulation for the same dosage regimen. On the other hand, following a t.i.d. dosage regimen, Tegretol suspension affords steady-state plasma levels comparable to Tegretol tablets given b.i.d. when administered at the same total mg daily dose. Tegretol chewable tablets may produce higher peak levels than the same dose given as regular tablets. Tegretol in blood is 76% bound to plasma proteins. Plasma levels of Tegretol are variable and may range from 0.5-25 µg/ml, with no apparent relationship to the daily intake of the drug. Usual adult therapeutic levels are between 4 and 12 µg/ml. Following chronic oral administration of suspension, plasma levels peak at approximately 1.5 hours compared to 4 to 5 hours after administration of oral tablets. The CSF/serum ratio is 0.22, similar to the 22% unbound Tegretol in serum. Because Tegretol may induce its own metabolism, the half-life is also variable. Initial half-life values range from 25-65 hours, with 12-17 hours on repeated doses. Tegretol is metabolized in the liver. After oral administration of ¹⁴C-carbamazepine, 72% of the administered radioactivity was found in the urine and 28% in the feces. This urinary radioactivity was composed largely of hydroxylated and conjugated metabolites, with only 3% of unchanged Tegretol. Transplacental passage of Tegretol is rapid (30 to 60 minutes), and the drug is accumulated in fetal tissues, with higher levels found in liver and kidney than in brain and lungs.

INDICATIONS AND USAGE

Epilepsy: Tegretol is indicated for use as an anticonvulsant drug. Evidence supporting efficacy of Tegretol as an anticonvulsant was derived from active drug-controlled studies that enrolled patients with the following seizure types:

- Partial seizures with complex symptomatology (psychomotor, temporal lobe). Patients with these seizures appear to show greater improvement than those with other types.
- Generalized tonic-clonic seizures (grand mal).
- Mixed seizure patterns which include the above, or other partial or generalized seizures.

Absence seizures (petit mal) do not appear to be controlled by Tegretol (see PRECAUTIONS, General).

Trigeminal Neuralgia: Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia.

Beneficial results have also been reported in glossopharyngeal neuralgia.

This drug is not a simple analgesic and should not be used for the relief of trivial aches or pains.

CONTRAINDICATIONS

Tegretol should not be used in patients with a history of previous bone marrow depression, hypersensitivity to the drug, or known sensitivity to any of the tricyclic compounds, such as amitriptyline, desipramine, imipramine, protriptyline, nortriptyline, etc. Likewise, on theoretical grounds its use with monoamine oxidase inhibitors is not recommended. Before administration of Tegretol, MAO inhibitors should be discontinued for a minimum of fourteen days, or longer if the clinical situation permits.

WARNINGS

Patients with a history of adverse hematologic reaction to any drug may be particularly at risk.

Severe dermatologic reactions including toxic epidermal necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome, have been reported with Tegretol. These reactions have been extremely rare. However, a few fatalities have been reported.

Tegretol has shown mild anticholinergic activity; therefore, patients with increased intraocular pressure should be closely observed during therapy.

Because of the relationship of the drug to other tricyclic compounds, the possibility of activation of a latent psychosis and, in elderly patients, of confusion or agitation should be borne in mind.

PRECAUTIONS

General: Before initiating therapy, a detailed history and physical examination should be made.

Examination should be used with caution in patients with a mixed seizure disorder that includes atypical absence seizures, since in these patients Tegretol has been associated with increased frequency of generalized convulsions (see INOICATIONS AND USAGE).

Therapy should be prescribed only after critical benefit-to-risk appraisal in patients with a history of cardiac, hepatic or renal damage, adverse hematologic reaction to other drugs, or interrupted courses of therapy with Tegretol.

Since a given dose of Tegretol suspension will produce higher peak levels than the same dose given as the tablet, it is recommended that patients given the suspension be started on lower doses and increased slowly to avoid unwanted side effects (see DOSAGE AND ADMINISTRATION).

Information for Patients: Patients should be made aware of the early toxic signs and symptoms of a potential hematologic problem, such as fever, sore throat, rash, ulcers in the mouth, easy bruising, petechial or purpuric hemorrhage, and should be advised to report to the physician immediately if any such signs or symptoms appear.

Since dizziness and drowsiness may occur, patients should be cautioned about the hazards of operating machinery or automobiles or engaging in other potentially dangerous tasks.

Laboratory Tests: Complete pretreatment blood counts, including platelets and possibly reticulocytes and serum iron, should be obtained as a baseline. If a patient in the course of treatment exhibits low or decreased white blood cell or platelet counts, the patient should be monitored closely. Discontinuation of the drug should be considered if any evidence of significant bone marrow depression develops.

Baseline and periodic evaluations of liver function, particularly in patients with a history of liver disease, must be performed during treatment with this drug since liver damage may occur. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.

Baseline and periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended since many phenothiazines and related drugs have been shown to cause eye changes.

Baseline and periodic complete urinalysis and BUN determinations are recommended for patients treated with this agent because of observed renal dysfunction.

Monitoring of blood levels (see CLINICAL PHARMACOLOGY) has increased the efficacy and safety of anticonvulsants. This monitoring may be particularly useful in cases of dramatic increase in seizure frequency and for verification of compliance. In addition, measurement of drug serum levels may aid in determining the cause of toxicity when more than one medication is being used.

Thyroid function tests have been reported to show decreased values with Tegretol administered alone.

Hyponatremia has been reported in association with Tegretol use, either alone or in combination with other drugs.

Drug Interactions: The simultaneous administration of phenobarbital, phenytoin, or primidone, or a combination of two, produces a marked lowering of serum levels of Tegretol. The effect of valproic acid on Tegretol blood levels is not clearly established, although an increase in the ratio of active 10, 11-epoxide metabolite to parent compound is a consistent finding.

The half-lives of phenytoin, warfarin, doxycycline, and theophylline were significantly shortened when administered concurrently with Tegretol. Haloperidol and valproic acid serum levels may be reduced when these drugs are administered with Tegretol. The doses of these drugs may therefore have to be increased when Tegretol is added to the therapeutic regimen.

Concomitant administration of Tegretol with erythromycin, cimetidine, propoxyphene, terfenadine, isoniazid, fluoxetine or calcium channel blockers has been reported to result in elevated plasma levels of total and/or free carbamazepine resulting in toxicity in some cases. Also, concomitant administration of carbamazepine and lithium may increase the risk of neurotoxic side effects.

Alterations of thyroid function have been reported in combination therapy with other anticonvulsant medications.

Breakthrough bleeding has been reported among patients receiving concomitant oral contraceptives and their reliability may be adversely affected.

Carcinogenesis, Mutagenesis, Impairment of Fertility:

Carbamazepine, when administered to Sprague-Cawley rats for two years in the diet at doses of 25, 75, and 250 mg/kg/day, resulted in a dose-related increase in the incidence of hepatocellular tumors in females and of benign interstitial cell adenomas in the testes of males.

Carbamazepine must, therefore, be considered to be carcinogenic in Sprague-Dawley rats. Bacterial and mammalian mutagenicity studies using carbamazepine produced negative results. The significance of these findings relative to the use of carbamazepine in humans is, at present, unknown.

Pregnancy Category C: Tegretol has been shown to have adverse effects in reproduction studies in rats when given orally in dosages 10-25 times the maximum human daily dosage of 1200 mg. In rat teratology studies, 2 of 135 offspring showed clefted ribs at 250 mg/kg and 4 of 119 offspring at 650 mg/kg showed other anomalies (cleft palate, 1; talipes, 1; anophthalmos, 2). In reproduction studies in rats, nursing offspring demonstrated a lack of weight gain and an unkempt appearance at a maternal dosage level of 200 mg/kg.

There are no adequate and well-controlled studies in pregnant women. Epidemiological data suggest that there may be an association between the use of carbamazepine during pregnancy and congenital malformations, including spina bifida. Tegretol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Retrospective case reviews suggest that, compared with monotherapy, there may be a higher prevalence of teratogenic effects associated with the use of anticonvulsants in combination therapy.

Therefore, monotherapy is recommended for pregnant women.

It is important to note that anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

Labor and Delivery: The effect of Tegretol on human labor and delivery is unknown.

Nursing Mothers: During lactation, concentration of Tegretol in milk is approximately 60% of the maternal plasma concentration.

Because of the potential for serious adverse reactions in nursing infants from carbamazepine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children below the age of 6 years have not been established.

ADVERSE REACTIONS

If adverse reactions are of such severity that the drug must be discontinued, the physician must be aware that abrupt discontinuation of any anticonvulsant drug in a responsive epileptic patient may lead to seizures or even status epilepticus with its life-threatening hazards.

The most severe adverse reactions have been observed in the hemopoietic system (see boxed WARNING), the skin and the cardiovascular system.

The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea, and vomiting. To minimize the possibility of such reactions, therapy should be initiated at the low dosage recommended.

The following additional adverse reactions have been reported: **Hemopoietic System:** Aplastic anemia, agranulocytosis, pancytopenia, bone marrow depression, thrombocytopenia, leukopenia, leukocytosis, eosinophilia, acute intermittent porphyria.

Skin: Pruritic and erythematous rashes, urticaria, toxic epidermal necrolysis (Lyell's syndrome) (see WARNINGS), Stevens-Johnson syndrome (see WARNINGS), photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, erythema multiforme and nodosum, purpura, aggravation of disseminated lupus erythematosus, alopecia, and diaphoresis. In certain cases, discontinuation of therapy may be necessary. Isolated cases of hirsutism have been reported, but a causal relationship is not clear.

Cardiovascular System: Congestive heart failure, edema, aggravation of hypertension, hypotension, syncope and collapse, aggravation of coronary artery disease, arrhythmias and AV block, primary thrombophlebitis, recurrence of thrombophlebitis, and adenopathy or lymphadenopathy.

Some of these cardiovascular complications have resulted in fatalities. Myocardial infarction has been associated with other tricyclic compounds.

Liver: Abnormalities in liver function tests, cholestatic and hepatocellular jaundice, hepatitis.

Respiratory System: Pulmonary hypersensitivity characterized by fever, dyspnea, pneumonitis or pneumonia.

Genitourinary System: Urinary frequency, acute urinary retention, oliguria with elevated blood pressure, azotemia, renal failure, and impotence. Albuminuria, glycosuria, elevated BUN and microscopic deposits in the urine have also been reported.

Testicular atrophy occurred in rats receiving Tegretol orally from 4 to 52 weeks at dosage levels of 50 to 400 mg/kg/day. Additionally, rats receiving Tegretol in the diet for two years at dosage levels of 25, 75, and 250 mg/kg/day had a dose-related incidence of testicular atrophy and aspermatogenesis. In dogs, it produced a brownish discoloration, presumably a metabolite, in the urinary bladder at dosage levels of 50 mg/kg and higher. Relevance of these findings to humans is unknown. **Nervous System:** Ooziness, drowsiness, disturbances of coordination, confusion, headache, fatigue, blurred vision, visual hallucinations, transient diplopia, oculomotor disturbances, nystagmus, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, tinnitus, and hyperacusis.

There have been reports of associated paralysis and other symptoms of cerebral arterial insufficiency, but the exact relationship of these reactions to the drug has not been established.

Digestive System: Nausea, vomiting, gastric distress and abdominal pain, diarrhea, constipation, anorexia, and dryness of the mouth and pharynx, including glossitis and stomatitis.

Eyes: Scattered punctate cortical lens opacities, as well as conjunctivitis, have been reported. Although a direct causal relationship has not been established, many phenothiazines and related drugs have been shown to cause eye changes.

Musculoskeletal System: Aching joints and muscles, and leg cramps. **Metabolism:** Fever and chills. Inappropriate antidiuretic hormone (AOH) secretion syndrome has been reported. Cases of frank water intoxication, with decreased serum sodium (hyponatremia) and confusion, have been reported in association with Tegretol use (see PRECAUTIONS, Laboratory Tests).

Other: Isolated cases of a lupus erythematosus-like syndrome have been reported. There have been occasional reports of elevated levels of cholesterol, HOL cholesterol and triglycerides in patients taking anticonvulsants.

A case of aseptic meningitis, accompanied by myoclonus and peripheral eosinophilia, has been reported in a patient taking carbamazepine in combination with other medications. The patient was successfully dechallenged, and the meningitis reappeared upon rechallenge with carbamazepine.

DRUG ABUSE AND DEPENDENCE

No evidence of abuse potential has been associated with Tegretol, nor is there evidence of psychological or physical dependence in humans.

OVERDOSAGE

Acute Toxicity

Lowest known lethal dose: adults, >60 g (39-year-old man). Highest known doses survived: adults, 30 g (31-year-old woman); children, 10 g (6-year-old boy); small children, 5 g (3-year-old girl).

Oral LD₅₀ in animals (mg/kg): mice, 1100-3750; rats, 3850-4025; rabbits, 1500-2680; guinea pigs, 920.

Signs and Symptoms

The first signs and symptoms appear after 1-3 hours. Neuromuscular disturbances are the most prominent. Cardiovascular disorders are generally milder, and severe cardiac complications occur only when very high doses (>60 g) have been ingested.

Respiration: Irregular breathing, respiratory depression. **Cardiovascular System:** Tachycardia, hypotension or hypertension, shock, conduction disorders.

Nervous System and Muscles: Impairment of consciousness ranging in severity to deep coma. Convulsions, especially in small children. Motor restlessness, muscular twitching, tremor, athetoid movements, opisthotonos, ataxia, drowsiness, dizziness, mydriasis, nystagmus, adiadochokinesia, ballism, psychomotor disturbances, dysmetria. Initial hyperreflexia, followed by hyporeflexia. **Gastrointestinal Tract:** Nausea, vomiting.

Kidneys and Bladder: Anuria or oliguria, urinary retention.

Laboratory Findings: Isolated instances of overdosage have included leukocytosis, reduced leukocyte count, glycosuria and acetonuria. EEG may show dysrhythmias.

Combined Poisoning: When alcohol, tricyclic antidepressants, barbiturates or hydantoins are taken at the same time, the signs and symptoms of acute poisoning with Tegretol may be aggravated or modified.

Treatment

The prognosis in cases of severe poisoning is critically dependent upon prompt elimination of the drug, which may be achieved by inducing vomiting, irrigating the stomach, and by taking appropriate steps to diminish absorption. If these measures cannot be implemented without risk on the spot, the patient should be transferred at once to a hospital, while ensuring that vital functions are safeguarded. There is no specific antidote. **Elimination of the Drug:** Induction of vomiting.

Gastric lavage. Even when more than 4 hours have elapsed following ingestion of the drug, the stomach should be repeatedly irrigated, especially if the patient has also consumed alcohol.

Measures to Reduce Absorption: Activated charcoal, laxatives. **Measures to Accelerate Elimination:** Forced diuresis.

Dialysis is indicated only in severe poisoning associated with renal failure. Replacement transfusion is indicated in severe poisoning in small children.

Respiratory Depression: Keep the airways free; resort, if necessary, to endotracheal intubation, artificial respiration, and administration of oxygen.

Hypotension, Shock: Keep the patient's legs raised and administer a plasma expander. If blood pressure fails to rise despite measures taken to increase plasma volume, use of vasoactive substances should be considered.

Convulsions: Oiazepam or barbiturates.

Warning: Oiazepam or barbiturates may aggravate respiratory depression (especially in children), hypotension, and coma. However, barbiturates should not be used if drugs that inhibit monoamine oxidase have also been taken by the patient either in overdosage or in recent therapy (within one week).

Surveillance: Respiration, cardiac function (ECG monitoring), blood pressure, body temperature, pupillary reflexes, and kidney and bladder function should be monitored for several days.

Treatment of Blood Count Abnormalities: If evidence of significant bone marrow depression develops, the following recommendations are suggested: (1) stop the drug, (2) perform daily CBC, platelet and reticulocyte counts, (3) do a bone marrow aspiration and trephine biopsy immediately and repeat with sufficient frequency to monitor recovery.

Special periodic studies might be helpful as follows: (1) white cell and platelet antibodies, (2) ⁵⁹Fe —ferrokinetic studies, (3) peripheral blood cell typing, (4) cytogenetic studies on marrow and peripheral blood, (5) bone marrow culture studies for colony-forming units, (6) hemoglobin electrophoresis for A₂ and F hemoglobin, and (7) serum folic acid and B₁₂ levels.

A fully developed aplastic anemia will require appropriate, intensive monitoring and therapy, for which specialized consultation should be sought.

DOSAGE AND ADMINISTRATION (see table below) Monitoring of blood levels has increased the efficacy and safety of anticonvulsants (see PRECAUTIONS, Laboratory Tests). Oosage should be adjusted to the needs of the individual patient. A low initial daily dosage with a gradual increase is advised. As soon as adequate control is achieved, the dosage may be reduced very gradually to the minimum effective level. Medication should be taken with meals.

Since a given dose of Tegretol suspension will produce higher peak levels than the same dose given as the tablet, it is recommended to start with low doses (children 6-12 years: 1/2 teaspoon q.i.d.) and to increase slowly to avoid unwanted side effects.

Conversion of patients from oral Tegretol tablets to Tegretol suspension: Patients should be converted by administering the same number of mg per day in smaller, more frequent doses (i.e., b.i.d. tablets to t.i.d. suspension).

Epilepsy (see INOICATIONS AND USAGE)

Adults and children over 12 years of age — Initial: Either 200 mg b.i.d. for tablets or 1 teaspoon q.i.d. for suspension (400 mg per day). Increase at weekly intervals by adding up to 200 mg per day using a t.i.d. or q.i.d. regimen until the optimal response is obtained. Oosage generally should not exceed 1000 mg daily in children 12 to 15 years of age, and 1200 mg daily in patients above 15 years of age. Ooses up to 1600 mg daily have been used in adults in rare instances.

Maintenance: Adjust dosage to the minimum effective level, usually 800-1200 mg daily.

Children 6-12 years of age — Initial: Either 100 mg b.i.d. for tablets or 1/2 teaspoon q.i.d. for suspension (200 mg per day). Increase at weekly intervals by adding up to 100 mg per day using a t.i.d. or q.i.d. regimen until the optimal response is obtained. Oosage generally should not exceed 1000 mg daily. **Maintenance:** Adjust dosage to the minimum effective level, usually 400-800 mg daily.

Combination Therapy: Tegretol may be used alone or with other anticonvulsants. When added to existing anticonvulsant therapy, the drug should be added gradually while the other anticonvulsants are maintained or gradually decreased, except phenytoin, which may have to be increased (see PRECAUTIONS, Drug Interactions and Pregnancy Category C).

Trigeminal Neuralgia (see INOICATIONS AND USAGE)

Initial: On the first day, either 100 mg b.i.d. for tablets or 1/2 teaspoon q.i.d. for suspension for a total daily dose of 200 mg. This daily dose may be increased by up to 200 mg a day using increments of 100 mg every 12 hours for tablets or 50 mg (1/2 teaspoon) q.i.d. for suspension, only as needed to achieve freedom from pain. Oo not exceed 1200 mg/daily.

Maintenance: Control of pain can be maintained in most patients with 400 mg to 800 mg daily. However, some patients may be maintained on as little as 200 mg daily, while others may require as much as 1200 mg daily. At least once every 3 months throughout the treatment period, attempts should be made to reduce the dose to the minimum effective level or even to discontinue the drug.

HOW SUPPLIED

Chewable Tablets 100 mg—round, red-speckled, pink, single-scored (imprinted Tegretol on one side and 52 twice on the scored side)

Bottles of 100.....NDC 58887-052-30

Unit Oose (blister pack)

Box of 100 (strips of 10).....NDC 58887-052-32

Do not store above 86°F (30°C). *Protect from light and moisture.*

Dispense in tight, light-resistant container (USP).

Tablets 200 mg—capsule-shaped, pink, single-scored (imprinted Tegretol on one side and 27 twice on the partially scored side)

Bottles of 100.....NOC 58887-027-30

Bottles of 1000.....NDC 58887-027-40

Unit Oose (blister pack)

Box of 100 (strips of 10).....NOC 58887-027-32

Do not store above 86°F (30°C).

Protect from moisture. Dispense in tight container (USP).

Samples, when available, are identified by the word **SAMPLE** appearing on each tablet.

Suspension 100 mg/5 ml (teaspoon)—yellow-orange, citrus-vanilla flavored

Bottles of 450 ml.....NOC 58887-019-76

Shake well before using.

Do not store above 86°F (30°C).

Dispense in tight, light-resistant container (USP).

Printed in U.S.A. C94-3 (Rev. 3/94)

BASEL Pharmaceuticals

Basel Pharmaceuticals
Ciba-Geigy Corporation
Summit, New Jersey 07901

Dosage Information: Tablets and Suspension					
Indication	Initial Dose		Subsequent Dose		Maximum Dose
	Tablet	Suspension	Tablet	Suspension	Tablet or Suspension
Epilepsy					
6-12 years of age	100 mg b.i.d. (200 mg/day)	1/ 2 teaspoon q.i.d. (200 mg/day)	Add up to 100 mg per day at weekly intervals, t.i.d. or q.i.d.	Add up to 1 teaspoon (100 mg) per day at weekly intervals, t.i.d. or q.i.d.	1000 mg/24 hours
Over 12 years of age	200 mg b.i.d. (400 mg/day)	1 teaspoon q.i.d. (400 mg/day)	Add up to 200 mg per day at weekly intervals, t.i.d. or q.i.d.	Add up to 2 teaspoons (200 mg) per day at weekly intervals, t.i.d. or q.i.d.	1000 mg/24 hours: 12-15 years 1200 mg/24 hours: over 15 years 1600 mg/24 hours: adults, in rare instances
Trigeminal Neuralgia	100 mg b.i.d. on the first day (200 mg/day)	1/ 2 teaspoon q.i.d. (200 mg/day)	Add up to 200 mg per day in increments of 100 mg every 12 hours	Add up to 2 teaspoons (200 mg) per day q.i.d.	1200 mg/24 hours

Altering records

(Continued from page 8)

a physician has altered records, the physician is referred to the Underwriting Committee, which decides if the alterations were egregious enough to warrant nonrenewal," Dr. Jensen explained. "And if physicians who have altered their records swear to the accuracy of their records on the [witness] stand, they are lying under oath. That is a criminal offense, which means they can be referred to the Medical Disciplinary Board. So, not only can physicians lose the case, which is bad enough, they also can lose their insurance coverage and may very well lose their license."

"ISMIE feels very strongly that physicians who alter records should be referred to underwriting for possible loss of coverage," agreed Jere Freidheim, MD, chairman of the Risk Management Committee. "And it happens with enough frequency that we feel [the serious consequences] must be brought to the attention of policyholders. A lot of doctors don't feel they're doing anything wrong – they think that they're just making their records reflect what they really did."

The Illinois Criminal Code of 1961 states that altering medical records and using them in a lawsuit are grounds for forgery or perjury charges. And the Medical Practice Act of 1987 considers "willfully making or filing false records

or reports in his or her practice as a physician grounds for discipline."

Examples of changes in medical records vary from case to case. Austin said they range from adding a notation about a test that was ordered but never entered in the file to clarifying original notes to destroying an original record and replacing it with a new, more accurate one. But no matter how simple or seemingly innocuous a physician considers an alteration, the jury will consider it an aberration. And the jury will find out the alteration was made, no matter how physicians try to camouflage it, he said.

"Some doctors are unaware that before a suit is filed, a plaintiff's attorney

obtains copies of the records. Most alterations are made after a doctor receives a summons," Austin said. "In one case, a record was very brief but fairly complete and written in acceptable medical language. The doctor went back and added a paragraph that only expanded on his original findings. At the trial, the plaintiff's attorney had blowups of the original records and the altered ones, which were displayed before the jury."

Camarra also noted that current methods of aging ink samples make it virtually impossible for physicians to alter records without detection of the change.

However, there are instances when, after seeing and treating a patient, a

physician has reason to review – and possibly even add to – the patient's chart.

"If you recall something that should have been noted in the chart a day, a month or a year after the patient has left, you can add it. But date and initial it," Dr. Jensen said. "That kind of addition is a legitimate afterthought."

"If you're looking at a patient's record at the end of the day and it doesn't look to be complete, [you should] date, time and initial any changes or corrections made," concluded Austin. "That way, if you ever have to go to court, you can explain why the change was made and that you did it in a timely and above-board fashion."

ISMIE underscores

(Continued from page 9)

average payout of \$184,000.

"While we maintain a strong track record by winning nearly 80 percent of our cases, the 20 percent on which we do pay has been consistently rising," Dr. Jensen explained. "These trends are very disturbing. They affect every policyholder. For now, these escalating costs are an inescapable reality and are the cause of this premium increase, [which is needed] to maintain our financial integrity."

Dr. Jensen stressed the importance of ISMIE's aggressive efforts in Springfield and Washington, D.C., to achieve tort reform. "We continue to fight for caps on noneconomic loss and other tort reform issues that can curb these accelerating trends."

In closing, Dr. Jensen reiterated ISMIE's unfaltering support for its policyholders. "As a constant in a changing world, we will remain committed to Illinois physicians – regardless of the changes that impact us all."

ISMIE holds elections for Board of Governors

Six members up for re-election, plus a new nominee, were elected to the ISMIE Board of Governors during the Annual Meeting in Oak Brook last month.

Members re-elected to three-year terms were James Borgerson, MD, of Mount Pulaski; Jere Freidheim, MD, of Chicago; Jane Jackman, MD, of Springfield; Robert Rear-don, MD, of Bloomington; Vasanth Surath, MD, of Chicago; and Fred White, MD, of Chilloicthe.

Richard Sperling, MD, of Skokie, was elected as a new member of the Board of Governors.

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PSYCHOANALYSIS AND MUSIC

Opera on the couch

A psychiatrist analyzes the great opera composers and explores the relationship between conflict and creativity.

BY RICK PASZKIET

A beautiful Japanese girl is betrayed by her lover and stabs herself; a decent soldier becomes a murderous, love-crazed outcast; a man who performs as a clown stabs his wife after learning of her affair. Are these the latest subjects of tabloid journalism?

No, they're Madame Butterfly, Don Jose and Canio/Pagliacci – the larger-than-life characters of grand opera.

Although opera and its psychological subtexts may seem far removed from the psychiatrist's couch, Eric Plaut, MD, a professor of clinical psychiatry and behavioral science at Northwestern University Medical School, has blended these two subjects. In his book *Grand Opera: Mirror of the Western Mind*, Dr. Plaut investigates the meaning behind 18 of the world's most acclaimed operas and the psychological backgrounds of their composers.

A practicing psychiatrist who treats many musicians and performing artists, Dr. Plaut has written about the connection between opera and psychology since 1986. He taught psychiatry at the University of California at San Francisco, Indiana University, Yale University and the University of Connecticut. Before coming to Northwestern in 1981, he served as commissioner of the Connecticut Department of Mental Health.

But Dr. Plaut's expertise goes beyond psychiatry; he is also qualified musically. A violist and singer, he performed with the Robert Shaw Collegiate Chorale during World War II. His music career, however, was sidetracked after he received a candid assessment of his musical talents from a teacher at Juilliard. He then decided to concentrate on medicine and completed his undergraduate and medical studies at Columbia University.

Dr. Plaut may not grace the stage of the Chicago Lyric Opera, but like the great composers themselves, he is intensely committed to grand opera and its ide-

als. "Grand opera is powerfully appealing. Its characters are driven by emotions of passionate intensity, their actions governed by feelings more than by rationality. This is what I find so fascinating about grand opera. It has the capacity to reach people at a great variety of emotional levels."

FROM THE FRENCH REVOLUTION to World War I, grand opera became the greatest artistic achievement. The opera houses built then became "great civic monuments, in some ways the era's temples," he added.

Why does grand opera continue to grasp our imaginations? "The stuff of grand opera is like that of Shakespeare or the classic Greek playwrights. It circumvents the trivial and explores the timeless themes of love and hate, forgiveness and vengeance, and loyalty and betrayal," he said. "There is no mild conflict in grand opera; everything is written large, in heroic dimensions."

"I have always been drawn to the composers and how their backgrounds and individual characters affected their music. It is the composers, not the librettists, who are the dominant figures in grand opera," Dr. Plaut continued. "Not only did the public view [composers] as heroes, they often viewed themselves that way."

Arrogant, narcissistic, demanding. These adjectives describe the composers of grand opera. Although they were towering people of genius, they also had their share of neuroses, psychoses and downright peculiar behavior. Consider the following facts:

- Beethoven constantly changed his living arrangements – 71 times in 30 years – and he often fantasized that he was of noble lineage.
- Puccini was frequently depressed, a compulsive womanizer and fond of practical jokes and obscene language.
- Offenbach, weighing only about 90 pounds, tended

PSYCHOANALYSIS AND MUSIC

toward anorexia, was a perfectionist and could not tolerate being alone.

- Wagner suffered from a narcissistic personality disorder and was preoccupied with his body his entire life.
- Bizet had a penchant for prostitutes, fathered an illegitimate child by his mother's maid and had an unhappy marriage to an emotionally disturbed woman.
- Mozart was a perpetual child and for the first 22 years of his life, was without direct parental supervision for only one week.

CLEARLY, BEING EMOTIONALLY well-adapted was not a prerequisite for greatness as an opera composer. In fact, these composers had enough problems to keep any psychiatrist busy. Phobias, manic-depression, persecution complexes and even castration anxiety can all be found in their backgrounds.

Of the 14 composers analyzed in the book, however, only Rossini can be diagnosed as overtly psychotic, said Dr. Plaut. Rossini idolized his mother and once said, "If the Virgin Mary in heaven turns out to be more beautiful than Mother, I shall cry for the rest of my life." After his mother's death, he was unable to write operas. When he turned 40, he slipped into 25 years of incapacitating depression, according to Dr. Plaut.

"I would never have put Rossini on the couch, but I certainly would have medicated him," he noted. "Rossini was what today we understand to be a manic-depressive, and his comic operas, most notably 'The Barber of Seville,' manifest his manic side."

If some of these composers had obtained access to psychiatric treatment, would the end of their problems have also brought the end of their creative genius? "Since Aristotle, great minds have explored the relationship between conflict and creativity," Dr. Plaut said. "In a sense, the access to and use of conflict gave the composers their inspiration. Unfortunately, access to conflict is painful and can sometimes cause severe psychological problems."

Creativity never just happens, according to Dr. Plaut. Whether a novelist, painter or composer, the creative artist cares deeply about the world – sometimes at the expense of relationships with others.

"The artist may have an unusual reaction to outside stimuli," explained Dr. Plaut. "The stimuli and perceptions may assume a relatively greater importance. This may lead to difficulties in the usual sequences of development and later difficulties in interpersonal relationships."

The composers' unresolved conflicts were often expressed in their operas. For instance, Wagner's obsession with his body and concerns about his paternity appeared repeatedly in all his operatic tragedies, especially "The Ring of the Nibelung."

"Many of Mozart's operas – such as 'Don Giovanni,' 'The Marriage of Figaro' and 'The Magic Flute' – play out Mozart's lifelong ambivalence toward his



Frank Frisari

father, who gave up his own musical career to foster his son's genius," said Dr. Plaut.

It's not surprising that grand opera's unforgettable characters – Carmen, Rigoletto, Boris Gudounov – share the same psychological problems as the composers who gave them life. Like the composers, the characters reacted to the social, political and religious pressures of the time.

THROUGHOUT HIS BOOK, Dr. Plaut used a modified Freudian psychoanalytic approach as a basis for his analysis of the composers. Why Freud? "Psychologies are products of their eras as much as anything else," he said. "Freud was very much a 19th-century man. His psychology sprang from and was a critique of the culture in which he lived. Freud's psychology is well-suited to the composers and their operas."

The 19th century gave us Freud and these great composers, but so far, the 20th century has produced a dearth of grand operatic works. "Of all the productions of the Chicago Lyric Opera between 1954 and 1980, only two were by composers in this century," said Dr. Plaut. "Opera is the medium par excellence for grand, heroic passions. But in this century, the passions of romantic love, religious fundamentalism and nationalistic fervor have wreaked such devastation that we have come to distrust them."

Still, as Dr. Plaut's book demonstrates, grand opera is an enduring art form. With its soaring music and dramatic plots, opera continues to fascinate, to enlighten and to depict the complexities of human motivation. ■

Delegates address health issues

A new trustee post, gun control and insurance industry reforms are among the topics physician leaders considered during the 1994 ISMS House of Delegates meeting April 22-24 in Oak Brook. By Kathleen Furore and Tamara Strom

Anti-tobacco efforts

Recognizing the addictive nature of nicotine and its effect on active and passive users, delegates passed two anti-tobacco resolutions — one supporting legislation that prohibits minors from possessing tobacco products and the other calling for a smoking ban on international flights. Only positive testimony about these measures was heard in reference committee and on the House floor.

Introduced by Vermilion County delegate Edward Warren, MD, the possession of tobacco by minors resolution was adopted without discussion. The resolution calling for a smoking ban on international flights was introduced by Raymond Dieter Jr., MD, a delegate for the DuPage County Medical Society. Specifically, the second measure directs ISMS to submit a resolution to the AMA house asking the AMA to urge appropriate government entities to prohibit smoking on international flights. Albino Bismonte Jr., MD, a Lake County delegate, moved to amend the measure by adding that ISMS should identify and commend those airlines that already ban smoking on those flights. The resolution was adopted as amended without debate.

Gun control

Delegates also debated the issue of gun control. The Cook County resolution urged ISMS to "recognize that gun violence is a public health problem and affirm the principle of banning the ownership, possession, purchase, sale, transport or transfer of handguns, semiautomatic and automatic weapons and their ammunition, except for genuine sporting weapons and for authorized law enforcement and security personnel." The mea-

ANNUAL MEETING WRAP-UP

sure also called for ISMS to submit a resolution to the AMA House of Delegates directing the national organization to adopt similar policy.

The reference committee heard heated debate on this topic. Supporters cited the escalation of violence and gun-related injuries and deaths in communities throughout Illinois. Some advocates mentioned slain ISMS member Martin Sullivan, MD, who was shot last year in his Wilmette office. But opponents characterized the resolution as anti-Constitutional, claimed gun violence is primarily an urban problem and equated banning weapons with banning motorcycles and automobiles, which are also responsible for serious and fatal injuries.

Although the reference committee recommended an amended resolution recognizing that gun violence is a public health problem and affirming existing ISMS policy regarding firearms and ammunition, the House referred the original resolution to the Board of Trustees.

Nurse practitioners

A resolution introduced by DeKalb County delegate Rosemary Lane, MD, to initiate, encourage and support passage of legislation that would create a nurse practitioner act was referred to the Board of Trustees for decision. The resolution also established a definition of nurse practitioners and stated that any practice act should require physicians to supervise nurse practitioners and sign treatment protocols. It also called for nurse practitioners to receive limited prescribing privileges within specific param-

eters outlined in the resolution.

Supporters noted that many states already have nurse practitioner practice acts and that these providers are certain to play a major role in the delivery of care under health system reform. They also said that nurse practitioners currently function under an RN license and that they are valuable members of the health care team — particularly in underserved areas of the state.

Opponents, however, voiced concerns that the ultimate goal of nurse practitioners is independent practice. They added that if nurses practice without direct physician supervision, the quality of patient care could suffer. In addition, opponents questioned whether it was appropriate for ISMS to participate in defining the scope of another profession.

The reference committee recommended a substitute resolution encouraging ISMS to cooperate with appropriate professional organizations involving nurse practitioners and other physician extenders to develop legislation containing the intent of the resolution. However, the delegates opted for referral to the Board.

Pre-existing conditions

The House adopted policy aimed at helping patients who have pre-existing medical conditions to obtain health insurance. The resolution, introduced by Sandra Olson, MD, chairman of the Cook County delegation, directed ISMS to support legislation that prohibits any organization issuing health insurance policies in Illinois from denying coverage based on pre-existing medical conditions. The resolution also advocated eliminating the waiting period for the Illinois Comprehensive Health Insurance Plan, state-supported health insurance coverage for medically high-risk individuals who cannot obtain private health insurance and who do not qualify for Medicaid. In addition, the resolution endorsed reducing the cost of CHIP coverage to equal standard insurance policies, eliminating the pre-existing condition clause and increasing the individual lifetime maximum coverage of CHIP policies to at least \$1 million.

Resident trustee position

Delegates overwhelmingly adopted a resolution containing the language necessary to change ISMS bylaws and create a nonvoting resident physician seat on the Society's Board of Trustees. The resolution was introduced by Jere Freidheim, MD, for the Board. Sam Page, MD, of Chicago, was elected to serve as the resident physician trustee. ■

New ISMS leaders assume posts

Before adjourning the 1994 Annual Meeting on April 24, delegates elected new ISMS leadership. Earlier in the day, Alan M. Roman, MD, a Flossmoor surgeon, was installed as ISMS president.

Other physicians elected to ISMS offices include President-elect Raymond Hoffmann, MD, of Rockford; First Vice President Sandra Olson, MD, of Chicago; Second Vice President David Littman, MD, of Highland Park; and Secretary-treasurer M. LeRoy Sprang, MD, of Evanston. The delegates also re-elected Speaker of the House Ulrich Danckers, MD, of River Forest, and Vice Speaker Richard Schmidt, MD, of Ottawa.

The ISMS trustees elected at the Annual Meeting were Richard Geline, MD, of Chicago; Arvind Goyal, MD, of Itasca; Harold Jensen, MD, of Harvey; Janis Orłowski, MD, of River Forest; and Richard Snodgrass, MD, of Moline. Immediate-past President Arthur Traugott, MD, of Urbana, assumed the position of trustee at-large. In addition, Sam Page, MD, was elected by the Resident Physicians Section as ISMS' first resident physician trustee, a nonvoting position on the Board. During its reorganization meeting April 24, the ISMS Board of Trustees elected Ronald Welch, MD, of Belleville, as its new chairman.

The House also elected AMA delegates and alternate delegates for 1995-96. The delegates are James Andersen, MD, of Oak Brook; Dennis Brown, MD, of Elk Grove Village; Clair Callan, MD, of Lake Forest; Dr. Danckers; Chester Danehower Jr., MD, of Peoria; Edward Fesco, MD, of LaSalle; Mitchell Glaser, MD, of Chicago; Lawrence Hirsch, MD, of Northbrook; Dr. Hoffmann; Dr. Roman; and John Schneider, MD, of Chicago. The alternate delegates are Rebecca Bezman, of Chicago; Joan Cummings, MD, of Hines; Dr. Geline; William Kobler, MD, of Rockford; William J. Marshall, MD, of Plainfield; Patricia Merwick, MD, of Elmhurst; Ronald Ruecker, MD, of Decatur; and Norman Scheibling, MD, of Springfield. Richard Bulger, MD, of Hinsdale, and Theodore Kanellakes, MD, of Joliet, were elected alternate delegates to fill unexpired terms from Jan. 1, 1995, to Dec. 31, 1995.

In addition, Joseph Skom, MD, of Chicago, was elected to a five-year term on the ISMS Judicial Panel. ■



Above: ISMS President-elect Raymond Hoffmann, MD (left), and Speaker of the House of Delegates Ulrich Danckers, MD, confer during the ISMS Annual Meeting last month. Top right: Reference Committee A Chairman Morgan Meyer, MD (left), makes a point as John Krueger, MD, looks on. Right: Chicago delegates Richard Biek, MD (left), and Harold Goodman, MD, discuss issues.

Photos by Matt Ferguson



Illinois' first lady champions child safety

ISMS ALLIANCE: Physicians' spouses learn more about the state's Help Me Grow program. By Anna Chapman

[OAK BROOK] Illinois' first lady, Brenda Edgar, detailed prevention activities launched under the auspices of the state's year-old Help Me Grow program for children in an

address to the ISMS Alliance April 22. During her presentation at the Alliance's installation luncheon, Edgar also praised the group's antiviolence campaign and domestic violence education efforts. After Edgar's speech, Carolyn Kobler, of Rockford, was installed as Alliance president.

"Children do not come with directions on how to help them grow up. Many times, parents need a helping hand to find an answer to a question or directions to a service," Edgar told the Alliance members.

The Help Me Grow program focuses on seven areas of prevention — safety, preventive health care, gang and violence prevention, child abuse prevention, drug and alcohol use prevention, intergenera-



Edgar

Matt Ferguson

tional activities, and parent and family involvement. Since its inception last year, more than 12,000 Illinoisans have participated in the program, which was established as a partnership with Ronald McDonald Children's Charities. The program also operates a hot line — (800) 323-GROW — through which parents can access or receive referrals to services and obtain answers to questions, she noted.

Help Me Grow also helps link expectant parents with prenatal health care services, Edgar said. "With a single call to the hot line, an expecting mother can learn of the nearest public clinic that offers prenatal care at little cost."

Automobile safety is another program priority, Edgar said, noting that car accidents are the No. 1 cause of accidental death and injury in children. In May 1993, the program began promoting the importance of child safety seats, she said. "Many people don't know that the state funds a safety seat loaner program that provides seats at a low cost to families that cannot afford them."

That service was augmented in March 1994 when Help Me Grow and the Illinois Department of Transportation teamed up to start the Chad Tag program, which provides child identification tags for safety seats in case a child is involved in an accident and cannot be identified.

Help Me Grow also co-sponsored a statewide child immunization week in October 1993, Edgar said. "There are many things we can't protect our children from, but we can protect them from childhood diseases."

The program has also developed a resource guide listing more than 700 violence prevention programs and alternatives to gang activities, Edgar said. "It is important to provide our communities with resources in the fight against violence. Government alone cannot solve all the problems of all the children. It takes everyone working together."

Edgar

(Continued from page 1)

would still allow fee for service as an option. He said that \$2 of every \$3 now pays for hospital care and that his goal is to substantially reduce the number of emergency room visits and long hospital stays that occur in the absence of ongoing, high-quality primary care. He added that he hopes he can rely on physician help and input in designing a "program to rescue this state from bankruptcy."

In addition, Edgar said he proposes allowing individuals who lose their jobs to purchase no-frills health care insurance at reasonable prices and letting small businesses pool efforts to purchase plans at the lowest possible costs. His reforms will provide Illinois residents with feasible alternatives to federal plans, which would increase taxes and bureaucracy, he said.

Although health care reform was the primary topic of Edgar's speech, he also mentioned the progress made during his tenure as governor. Among the accomplishments he cited were holding down corporate taxes; increasing the number of manufacturing jobs in the state; keeping Illinois' unemployment rate below the national average; and hiring case workers and prison guards while reducing by 3,000 the number of state employees.

Edgar concluded by saying he continues "to count on the medical profession to be involved in the political process."

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CONTRAINDICATIONS

Diclofenac in either formulation, Catalam or Voltaren, is contraindicated in patients with hypersensitivity to diclofenac. Diclofenac should not be given to patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactoid-like reactions to diclofenac have been reported in such patients.

WARNINGS

Gastrointestinal Effects

Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac even in the absence of previous G.I. tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy: Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous G.I. tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper G.I. ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious G.I. toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious G.I. events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients may be more susceptible to ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal G.I. events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of G.I. toxicity.

Hepatic Effects

As with other NSAIDs, elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [= the Upper Limit of the Normal range]), or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to the enzyme elevations seen in clinical trials, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, have been reported.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Based on this experience, if diclofenac is used chronically, the first transaminase measurement should be made no later than 8 weeks after the start of diclofenac treatment. As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), diclofenac should be discontinued.

To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms), and the appropriate action patients should take if these signs and symptoms appear.

PRECAUTIONS

General

Allergic Reactions: As with other NSAIDs, allergic reactions including anaphylaxis have been reported with diclofenac. Specific allergic manifestations consisting of swelling of eyelids, lips, pharynx, and larynx; urticaria; asthma; and bronchospasm, sometimes with a concomitant fall in blood pressure (severe at times) have been observed in clinical trials and/or the marketing experience with diclofenac. Anaphylaxis has rarely been reported from foreign sources, in U.S. clinical trials with diclofenac in over 6000 patients. 1 case of anaphylaxis was reported. In controlled clinical trials, allergic reactions have been observed at an incidence of 0.5%. These reactions can occur without prior exposure to the drug.

Fluid Retention and Edema: Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac compensation, hypertension, or other conditions predisposing to fluid retention.

Renal Effects: As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In renal dysfunction studies in animals, some evidence of renal toxicity was noted. Isolated incidents of papillary necrosis were observed in a few animals at high doses (20-120 mg/kg) in several baboon subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during which serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients: creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

Purpura: The use of diclofenac in patients with hepatic purpura should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of purpura. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

Information for Patients

Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, there are more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

Laboratory Tests

Because serious G.I. tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac; these symptoms may become evident between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects).

Drug Interactions

Aspirin: Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

Anticoagulants: While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised, nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

Digoxin, Methotrexate, Cyclosporine: Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine's nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be monitored.

Lithium: Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

Dral Hypoglycemics: Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experiences of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic effects have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

Diuretics: Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

Other Drugs: In small groups of patients (7-10 interaction study), the concomitant administration of azathioprine, gold, chloroquine, D-penicillamine, prednisone, doxycycline, or digoxin did not significantly affect the peak levels and AUC values of diclofenac.

Protein Binding

In vitro, diclofenac interacts minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), ibuprofen, prednisone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlorotetracycline, doxycycline, cephalothin, erythromycin, and sulfamethoxazole have no influence in vitro on the protein binding of diclofenac in human serum.

Drug/Laboratory Test Interactions

Effect on Blood Coagulation: Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII. Statistically significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree; therefore, patients who may be adversely affected by such an action should be carefully observed.

Teratogenic Effects

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day (or 12 mg/m²/day, approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m²/day) female rats (high-dose females had excessive mortality), but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m²/day) in males and 1 mg/kg/day (3 mg/m²/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in in vitro point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was nonmutagenic in several mammalian in vitro and in vivo tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m²/day) did not affect fertility.

There are no adequate and well-controlled studies in pregnant women. Diclofenac should be used during pregnancy only if the benefits to the mother justify the potential risk to the fetus.

Pregnancy Category B: Reproduction studies have been performed in mice given diclofenac sodium (up to 20 mg/kg/day or 60 mg/m²/day) and in rats and rabbits given diclofenac sodium (up to 10 mg/kg/day or 60 mg/m²/day for rats, and 80 mg/m²/day for rabbits), and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats.

Labor and Delivery

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during late pregnancy should be avoided and, as with other nonsteroidal anti-inflammatory drugs, if possible that diclofenac may inhibit uterine contraction.

Nursing Mothers

Diclofenac has been found in the milk of nursing mothers. As with other drugs that are excreted in milk, diclofenac is not recommended for use in nursing women.

Pediatric Use

Safety and effectiveness of diclofenac in children have not been established.

Geriatric Use

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

ADVERSE REACTIONS

Adverse reaction information is derived from blinded, controlled and open-label clinical trials, as well as worldwide marketing experience. In the description below, rates of more common events represent clinical study results; rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In a 6-month, double-blind trial comparing Catalam Immediate-Release Tablets (N = 196) vs. Voltaren Delayed-Release Tablets (N = 197) vs. ibuprofen (N = 197), adverse reactions were similar in nature and frequency. In 718 patients treated for shorter periods, i.e., 2 weeks or less, with Catalam Immediate-Release Tablets, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods.

The incidence of common adverse reactions (greater than 1%) is based upon controlled clinical trials in 1543 patients treated up to 13 weeks with Voltaren Delayed-Release Tablets. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or G.I. bleeding occurred in clinical trials in 0.6% (95% confidence interval: 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval: 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%).

Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times the ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

Incidence Greater Than 1% - Causal Relationship Probable (All derived from clinical trials.)

Body as a Whole: Abdominal pain or cramps,* headache,* fluid retention, abdominal distention.

Digestive: Diarrhea,* indigestion,* nausea,* constipation,* flatulence, liver test abnormalities,* PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

Nervous System: Dizziness.

Skin and Appendages: Rash, pruritus.

Special Senses: Tinnitus.

*Incidence: 3% to 9% (incidence of unmarked reactions is 1%-3%).

Incidence Less Than 1% - Causal Relationship Probable (The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Malaise, swelling of lips and tongue, photosensitivity, anaphylaxis, anaphylactoid reactions.

Cardiovascular: Hypertension, congestive heart failure.

Digestive: Vomiting, jaundice, melena, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, hepatic necrosis, appetite change, pancreatitis with or without concomitant hepatitis, colitis.

Hemic and Lymphatic: Hemoglobin decrease, leukopenia, thrombocytopenia, hemolytic anemia, aplastic anemia, agranulocytosis, purpura, allergic purpura.

Melabolic and Nutritional Disorders: Azotemia.

Nervous System: Insomnia, drowsiness, depression, diplopia, anxiety, irritability, aseptic meningitis.

Respiratory: Epistaxis, asthma, laryngeal edema.

Skin and Appendages: Alopecia, urticaria, eczema, dermatitis, bullous eruption, erythema multiforme major, angioedema, Stevens-Johnson syndrome.

Special Senses: Blurred vision, taste disorder, reversible hearing loss, scotoma.

Urogenital: Nephrotic syndrome, proteinuria, oliguria, interstitial nephritis, papillary necrosis, acute renal failure.

Incidence Less Than 1% - Causal Relationship Unlikely (Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Chest pain.

Cardiovascular: Palpitations, flushing, tachycardia, premature ventricular contractions, myocardial infarction.

Digestive: Esophageal lesions.

Hemic and Lymphatic: Bruising.

Melabolic and Nutritional Disorders: Hypoglycemia, weight loss.

Nervous System: Paresthesia, memory disturbance, nightmares, tremor, tic, abnormal coordination, convulsions, disorientation, psychotic reaction.

Respiratory: Dyspnea, hyperventilation, edema of pharynx.

Skin and Appendages: Excess perspiration, exfoliative dermatitis.

Special Senses: Vicious floaters, night blindness, amblyopia.

Urogenital: Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

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PHO study

(Continued from page 1)

gathered from eight PHOs throughout the country, including one at Rockford's SwedishAmerican Hospital. For the study's purposes, a PHO was defined as a "legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives." The PHOs in the study were 50-50 joint ventures between physicians and hospitals, and most were legally organized as not-for-profit corporations, according to the study's executive summary.

"In a PHO, hospitals and physicians come together to form a new organization that is capable of signing contracts either with insurers or HMOs or directly with employers," said an ISMS analyst. "The idea is to be able to offer a full spectrum of physician and hospital care managed under one package."

The study's primary goals were to obtain firsthand information from physicians and hospital and PHO executives, understand key PHO success factors, disseminate information to help physicians evaluate PHOs as a potential option and enable medical society staff to learn more about PHOs so that they can assist members, according to the study analysis.

Although it focuses exclusively on PHOs, the study is not an endorsement of the concept of managed care, an ISMS analyst noted. "PHOs are the buzzword of the health care field this year, but they are only one in a series of options avail-

able to physicians. There is no one answer that will fulfill everyone's needs, but if the circumstances are right, it may be something physicians should consider."

"We wanted as broad a cross section of PHOs as possible, even though we were analyzing only eight," Gorey said, adding that the PHOs in the study operate in markets with either heavy or light managed care activity. The study also focused on new and older PHOs to get a sense of how the organizations mature, he added.

PHO study free to members

As a membership benefit, when the PHO study is available for distribution, ISMS will provide it free to members. Physicians may order the survey now by calling the ISMS health care finance division at (312) 782-1654 or (800) 782-ISMS.

A CRITICAL ELEMENT in the formation of PHOs is the existence of a physician organization, the study showed. "Repeatedly, in discussions with physician and hospital representatives from PHOs that had POs (six of the eight studied), the point was made as to the

essential role played by the POs in all phases of PHO planning, development, operations and policy-making," the summary noted.

"A PO performs a critical function in representing physicians' interests in the PHO, in keeping physicians informed of PHO developments, in facilitating decision-making, and in providing physicians with a 'buy in' to the PHO," the study analysis stated. "Regardless of the form a PO takes, it is important for the member physicians to understand that they are involved in a business venture that will require adequate capitalization, capable administrative support and an ongoing source of revenue."

"We were surprised to find that hospital administrators were 100-percent behind the formation of POs," Gorey noted.

Another essential component in forming a PHO is trust between the participating physicians and the hospital, the study found. "What characterized the successful PHOs was a sense of common mission, a sense of respect for the other person's perspective and an unwillingness to engage in turf battles at the expense of the broader good," said an ISMS analyst.

Physicians and hospital administrators interviewed for the study emphasized the need for primary care physicians to play a prominent role in all phases of PHO development and operations, the summary said. Although most of the PHOs studied stressed the importance of empowering primary care physicians to

lead PO and PHO policy-making, most had not established primary-care-controlled governance structures, the summary noted.

"Most PHOs currently are struggling, or soon will be, with the issue of how to address a possible imbalance between the number of primary care physicians and specialists in their membership," the analysis stated. "Efforts to recruit and retain primary care physicians will intensify, as will efforts to narrow the panel of specialists."

Calling information systems the "heart and soul of a good PHO," the summary cited agreement among all study participants that a sophisticated computer information system is vital. Nevertheless, participants were not completely satisfied with the systems they had established. "Virtually all PHO representatives lamented the fact that they had not moved more aggressively to put in place an adequate information system," the summary stated.

PHOs that are properly organized, capitalized, governed and administered can function effectively in various markets, including competitive managed care settings, the summary concluded. However, PHO administrators must have a keen understanding of the local market and be responsive to payers' needs. "Developing a sound managed care strategy, based on an in-depth market analysis, is critical to the success of a PHO."

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Payers' reviews

(Continued from page 1)

Morse continued. "If the patient is not enrolled or insured by the entity requesting the records, records may not be disclosed without the consent of the patient unless there is a valid subpoena or court order or a specific statutory requirement for their disclosure."

Health plans claim they are asking to review randomly pulled nonmember records as part of risk management and record-keeping checks, said Kirk McMurray, executive director of the DuPage County Medical Society. "Our concern is that they are very assertive. Physicians feel as though they are caught between upholding patient confidentiality and getting the contract."

McMurray said he received complaints from physicians in a group practice in which each physician was a member of the same managed care plan. A new physician joined the practice and applied for a contract with the plan. During the credentialing process, a nurse asked to review random patient records. The physicians refused.

If the physician had been denied a contract for refusing to submit to a random record review, the patients would have been penalized, McMurray said. Patients in the plan could see any physician in the group, but if a physician was denied a contract, patients would have to pay more to see that physician.

Another concern is that reviewers sometimes approach office staff without the physician's knowledge, McMurray noted.

"Physicians should let their staff know that they should be told if anyone requests to look at medical records," said Bennett Kaye, MD, a Chicago pediatrician who recently discovered a health plan reviewer examining nonplan records in his office. "The medical record really is a very special document. Without expressed permission or a summons, no one has a right to look at it."

Some insurers have recommended removing patient identifiers from the medical records to avoid breaching confidentiality, Morse said. But it may be impossible to remove all identifiers, he noted. "Even if you remove the name, address, Social Security number, insurance number and other information, it may still be possible to identify the patient. Especially in rural areas, the description of the patient combined with the diagnosis could be enough to disclose the identity of the patient."

Patient records are not the only information payers are seeking in the credentialing or recredentialing process, Morse warned. ISMS has also learned that some payers are requesting information on open professional liability claims. "These files, when held by the malpractice insurer, are protected from discovery and disclosure by plaintiffs' attorneys. This is because the professional liability insurer has an attorney-client privilege with the insured. If plaintiffs' attorneys learn that this information has been transmitted to a third-party payer, they can subpoena the records. This could disclose highly confidential information, including trial strategy."

Members who have received requests about open claims or review of random nonplan patient records or who have questions about potentially inappropriate payer reviews should contact Morse at ISMS, (217) 528-5609. ■

President's letter

(Continued from page 6)

glass is half-empty, and a realist knows that if he sticks around he will eventually have to wash the glass. As president, I can communicate with Springfield in 30 seconds, but it may take years for an idea to get through the quarter-inch-thick human skull. People acquire particular qualities by consistently acting in a particular way. So if you want to change attitudes, you need to start with a change in behavior. Think of how hard it is to change others, then just consider how difficult it is to change yourself.

Regardless of the game you play, certainly 90 percent of success comes from the neck northward. What is possible is limited only by your determination.

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would like to be treated ourselves are the underpinnings of a view that serves as an inspiration for everything we do each and every day. How you choose to mix and match your talents is limited only by your imagination and your attitude. You can overcome obstacles with strong-willed optimism.

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Illinois Medicine

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ISMS BEHIND THE SCENES

PUSH CONTINUES FOR UR LEGISLATION

A utilization review bill in the Illinois House of Representatives would pave the way for meaningful regulatory relief for Illinois physicians and hospitals, according to ISMS analysts. The measure, H.B. 4050, was prompted by the Illinois Hospital Association and resembles an ISMS bill also introduced this session. The ISMS bill failed in the House Insurance Committee, because of heavy opposition from business and insurance groups, a Society analyst said.

H.B. 4050, sponsored by Rep. Louis Lang (D-Skokie), was considered by the House Judiciary I Committee. Lang, who chairs the committee, was able to secure the necessary votes for this bill to emerge from committee and advance to the House floor, the analyst noted.

At the direction of the ISMS Board of

Trustees, the Society filed an amendment to H.B. 4050 – the Patient Protection Utilization Review Act – that includes physicians' concerns regarding liability and Illinois licensure of physicians who perform utilization review, he said. The amendment includes three key provisions to protect patients from unqualified UR review agents, ensure fairness in the UR process and make UR agents liable for their actions, just as treating physicians are, the analyst explained. As proposed, the amendment does the following:

- Mandates that physicians who are employed by UR entities and make determinations about the type of care provided have an Illinois license to practice medicine;
- Requires UR agents to employ a physician in

(Continued on page 15)

Gubernatorial candidates pledge support for mental health

SPEECHES: Edgar and Netsch offer their ideas to improve services. By Kathleen Furore

[CHICAGO] In May 2 addresses to the Mental Health Association in Illinois, Gov. Jim Edgar and his Democratic challenger, Comptroller Dawn Clark Netsch, promised to support programs and services that will enhance the state's mental health care system.

Edgar began his remarks by thanking the association for helping his administration make "significant progress" in reforming the mental health system in Illinois. "This has been a true partnership in progress – progress that was desperately needed, progress we cannot rest upon, progress that demands to be built upon." The governor then listed the mental-health-related accomplishments achieved since he took office almost four years ago.

"Soon after I became governor, representatives of your association and other mental health advocates paid a surprise inspection on one of our mental health facilities – Chicago Read [Mental Health Center] here in Chicago," he said. As a result of those inspections, Edgar – who said he was outraged at

the deplorable conditions uncovered – appointed a new director and inspector general for the Department of Mental Health and Developmental Disabilities and made a commitment to develop a "comprehensive and visionary network to meet the needs of people with mental illness."

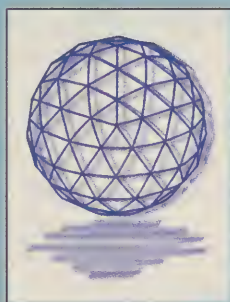
"Your commitment and mine has gone far beyond just assuring quality care," Edgar continued. "It has acted to bolster mental health services in cities and towns throughout Illinois so that people could remain near their loved ones and, when possible, remain in the mainstream of their communities."

Edgar noted that staff-to-patient ratios at mental health facilities will increase by more than 24 percent and state spending on community-based services will rise by 40 percent if the legislature approves his proposed mental health budget. In addition, community agencies this year prescreened about 46 percent of the people seeking voluntary admission to state facilities and will prescreen an

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INSIDE

Primary care physicians are joining ranks



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Legislators consider state Medicaid reform

TESTIMONY: ISMS submits written support for the governor's proposal. By Kathleen Furore and Anna Chapman

[SPRINGFIELD] State legislators began an intensive markup of Gov. Jim Edgar's Medicaid reform proposal May 20 during a joint hearing of the House General Services and Human Services appropriations committees. Representatives of nearly 25 interested groups – including ISMS, hospitals, HMOs and advocates of Medicaid recipients – presented testimony as lawmakers conducted a section-by-section analysis of the plan.

"The state needs to be responsive to changes [in the medical marketplace] as they occur," said Jim Reilly, Edgar's chief of staff, who presented the draft legislation before the markup.

Several Democratic committee members, however, questioned the governor's claims that a managed care system for Medicaid can be implemented in a timely manner and save the amount of money predicted by the administration.

Most of the groups that testified said they support the concept of forming an integrated

health care system for Medicaid. Physicians strongly believe that fee-for-service options must be included in such a system, according to an ISMS analyst.

But during legislative deliberations, substantial opposition surfaced toward some components of the governor's proposal that physicians consider critical for maintaining high-quality patient care, the analyst said. For example, many business and HMO representatives expressed strong concerns about the "any willing provider" provisions in the administration's plan, he said. And other groups are working hard to reverse ISMS efforts to maintain fee-for-service flexibility and guarantee that utilization review and quality assurance programs are developed and implemented by physicians, he added.

Despite steadily increasing resistance to those physician-supported provisions, ISMS is lobbying strongly to retain those elements, the analyst said.

"ISMS is working hard to assist the state in designing an appropriate response to the problems of Medicaid," said ISMS President Alan M. Roman, MD, in written testimony submitted to the House Health Care and Human Services Committee, which held a May 10 hearing on the governor's plan. "We urge that all parties redouble their efforts to see that our most vulnerable population has the access and quality of care we would want for ourselves and our families."

In the ISMS testimony (Continued on page 12)



Reilly

Ron Ackerman

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CHICAGO STUDENTS participate in a children's health fair sponsored by Rush-Presbyterian-St. Luke's Medical Center.

Suicide rate decreases with Canadian gun control law

[WASHINGTON] Data published by Statistics Canada revealed a decrease in the rate of gun suicides immediately after federal gun control legislation was adopted in Canada in 1978, according to a report in the American Psychiatric Association's newsletter *News Briefs*.

The report – summarizing a story in the April 1994 issue of the *American Journal of Psychiatry* – said that from 1965 through 1977, an average of 30 percent of Canada's total annual suicides was committed with firearms. Post-gun-control legislation statistics, however, showed that the average dropped to 26

percent and that other methods of suicide did not increase during that time.

The legislation restricted the purchase of all types of guns and required the adoption of safe handling and storage practices, the report explained.

"While we can't explain the declining trend in the nonfirearm suicide rate after 1978, our research does show that immediately after the legislation, there was a drop in the level of firearm suicide," said Peter Carrington, PhD, associate professor of sociology at the University of Waterloo, Ontario, who studied the suicide statistics. "This reduction was certainly not offset by an increase in nonfirearm suicides because, in fact, it was accompanied by a corresponding drop in the total suicide rate." ■

Area hospitals, medical schools affiliate

[CHICAGO] Affiliation agreements are progressing to pair two Chicago-area medical schools with two hospitals in the city, according to a spokesperson at Chicago's Cook County Hospital. An agreement linking Loyola University's Stritch School of Medicine and Provident Hospital was approved by the Cook County Board on May 17, according to a county board spokesperson. No board action has yet been taken on a similar affiliation between Rush Medical College and Cook County Hospital.

The partnerships will enhance primary and family care at Provident; increase expertise in surgery, infectious diseases, cardiology, endocrinology and neurology at County; attract more resident physicians to the medical centers; and boost the hospitals' status so that they will be counted among the premier teaching hospitals in the nation, officials noted.

The medical schools are moving ahead with plans for residents to begin rotations by midsummer. "On July 1, all surgical residents at Rush will be taking rotations at County Hospital," said Avery Miller, Rush's vice president of institutional affairs, in the April 27 edition of the *Chicago Sun-Times*. "It will be good for both institutions." Attempts by *Illinois Medicine* to reach Miller for comment were unsuccessful.

The cooperation between Loyola and Provident will be beneficial for both institutions, according to Daniel Winship, MD, dean of the Loyola medical school. He said it will enable Loyola to expand its primary care teaching programs and will give Provident an academic component that will enhance quality of care. "This is a real opportu-

nity for us to add a dimension to our program – particularly in the areas of education and primary care clinical programs – that we haven't had and need to develop," Dr. Winship explained. "Primary care is the way medicine is going, and Provident is a community hospital with a primary care base. [It wants] to be a teaching hospital and believes an affiliation with an academic medical center is the path to quality." ■

Physicians help victims of war in Bosnia

CONFLICT: Illinois doctors donate treatment to injured patients.

By Kathleen Furore

[CHICAGO] There might seem to be little that individuals can do to help the war effort in Bosnia, but some Chicago physicians are doing their part by providing free treatment to victims of the war. Among the doctors working with patients from Sarajevo are Scott Cordes, MD, an orthopedic surgeon at Northwestern Memorial Hospital; Shireen Ahmad, MD, an anesthesiologist at Northwestern; and Peter Geldner, MD, a plastic and reconstructive surgeon at Michael Reese Hospital and Medical Center.

"What's happening in Bosnia is clearly a political and social disaster. And though I'm only touching one person at a time, I feel great about being able to help," Dr. Geldner said. "It is very gratifying to be able to help in some small way."

The ways in which these physicians are helping, however, are not small. Dr. Cordes, for example, performed a bone graft and bone transport on 24-year-old Samir Zuhric, whose lower left leg was shattered almost two years ago by a grenade tossed near his home. The procedures helped save Zuhric's leg, which was so infected when he arrived in Chicago in January that Dr. Cordes said he was "very close to amputation." And Dr. Ahmad not only found housing for Zuhric but is also funding it.

Dr. Geldner mended 26-year-old Selver Hasanovic's gaping heel wound, which extended to the bone, and he designed a skin flap that closed the large shrapnel wound on 69-year-old Hasan Kazija's left knee. "Selver's heel is almost completely healed and the lateral contour of his foot is almost normal. Hasan is doing fine. We thought he'd

lose a range of motion in his knee, but the range is excellent, and the wound remains closed," Dr. Geldner said.

THE JOURNEYS of these Bosnian patients were arranged in different ways. Dr. Ahmad was "searching for ways to help Bosnians" and discovered she could bring patients to the United States with the help of the government-funded International Organization for Migration and the United Nations' MedVac program.

"The MedVac group in Bosnia evaluates patients and decides who is appropriate [for transport to other countries]," Dr. Ahmad explained. "Then IOM uses Air Force planes to bring patients to America. They provide us with the patients' medical histories, which they get from the United Nations physicians." Zuhric was one such patient, she said.

According to a Michael Reese spokesperson, Kazija and Hasanovic – along with two other war victims and several family members – came to Chicago as the result of conversations between Jana's House, a Sarajevo-based humanitarian foundation, and Rick Scott, CEO of Columbia/HCA, Michael Reese's parent company. Jana's House was established by Chicago free-lance journalist Ellen Blackman, who has lived in Sarajevo for almost a year.

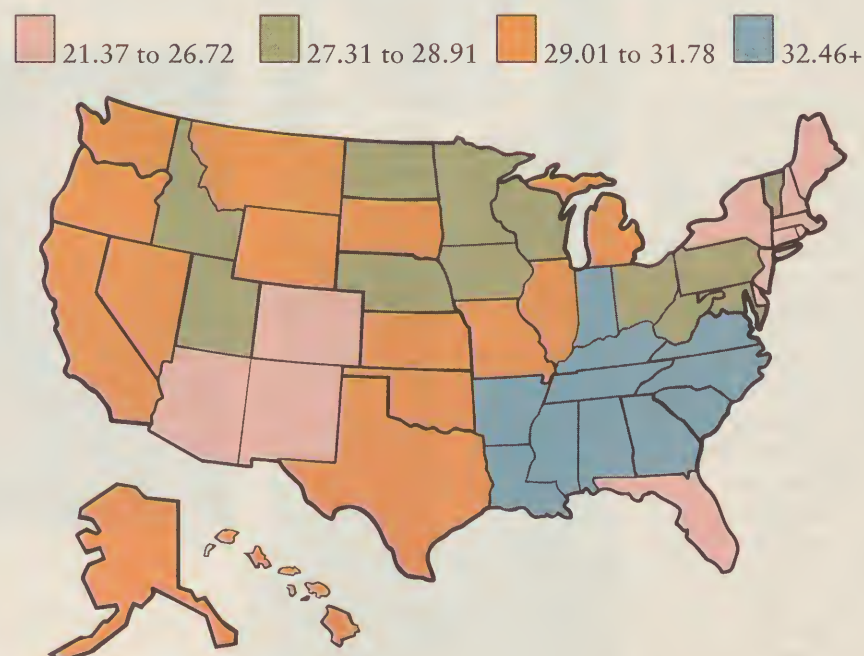
"Rick Scott was approached by a representative of Jana's House for medical assistance, and he said, 'We'd be glad to help,'" said a spokesperson for Columbia/HCA. She added that patients were also transported to the University of Louisville Hospital, another Columbia/HCA network member.

Dr. Cordes said he gave his time and talent to help a Bosnian patient "because I knew how to do the surgery Samir needed. To be able to use four hours of my time to save someone's leg – it's well worth it."

Dr. Cordes' patient, Zuhric, said his journey and the treatment have been worthwhile. "I was excited to come to America, and I am very satisfied with the good care I am getting at Northwestern," he commented through his interpreter. "I know the reality; I may never be quite like I was. But I am determined to walk again and return to my family in Bosnia." ■

PHYSICIAN FACTS

Stroke fatalities per 100,000 population*



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Primary care physicians are joining ranks

Medical groups are emphasizing quality care, service and cost containment. By Anna Chapman

New opportunities are available for primary care physicians as the medical marketplace reacts to a perceived imbalance between primary and specialty care physicians, according to medical directors of two Chicago-area managed care entities — Health Spring Medical Group and the Dreyer Medical Clinic.

"There is clearly care to be given by the primary care physician beyond acting as a triage agent for the specialist,"

said Kaveh Safavi, MD, president and medical director of the Health Spring Medical Group, which manages primary care medical groups.

Dr. Safavi and Mark Shields, MD, medical director of the Dreyer Medical Clinic in Aurora, outlined the roles of primary care physicians in their organizations during the May 2 spring symposium of the Illinois Association of HMOs.

The Health Spring Medical Group has been developing primary care group practices for nearly two years, Dr. Safavi said. The organization focuses on building primary care group practices — including internists, family physicians, pediatricians and Ob/Gyns — that are dedicated to maintaining quality care and service at the best available cost, he said. "At our core, we are a medical group. We are not an HMO or insurance company, and we're not a management service company."

Currently, Health Spring has practices in three cities including Chicago, and the organization plans to expand to seven regional locations by 1998, Dr. Safavi said. A nine-physician primary care group in Bloomingdale will soon join Health Spring and will hold several managed care contracts, he added.

Health Spring distributes funds on a full-service capitation basis, not a primary care capitation basis, Dr. Safavi explained. Under primary care capitation models, physicians are paid only for primary care services and therefore have a "tremendous incentive to move care outside of their discipline — into the emergency room, into laboratory services, into the specialist's office." Although the primary care groups and specialists form strong working relationships, the specialists maintain independent practices, Dr. Safavi added.

Physicians in Health Spring group practices are responsible for managing the entire spectrum of health care, including financial resources, he noted. "We believe that fundamentally it is both good and right for the medical providers to feel a sense of responsibility and accountability for those resources."

Health Spring physicians are also required to take considerable responsibility for patients, even ensuring that those who need care are able to enter the system. "We are not a gatekeeper," Dr. Safavi noted. He said he believes that gatekeepers allow access to care without actually providing care. Instead, Health

Spring physicians develop and refine primary care skills and use them to treat patients, he said.

THE DREYER MEDICAL CLINIC operates five facilities in the Fox Valley area just west of Chicago. The clinic was established in 1922 and has participated in managed care programs for 15 years, Dr. Shields said. "There is now an infrastructure for

managed care that was not available 15 to 20 years ago," he said.

After analyzing statistics from large staff model HMOs like Kaiser Permanente, Dreyer shifted its recruiting efforts a year ago. The clinic plans to reach a target of 50 percent primary care physicians within two years, Dr. Shields said. "Now we are recruiting almost exclusively primary care doctors. This has

been a significant difference in our strategic plan.

"We are who we recruit," Dr. Shields continued. "[Recruiting] is the major activity of the whole group. We need to have a panel of physicians [that is] committed to managed care and understands it."

As part of its overall move toward managed care, Dreyer has also emphasized the importance of reporting mechanisms to provide detailed information to consumers, Dr. Shields said. "Clinical information systems will be a major determinant of winners and losers in the future health care system. The ability to retrieve clinically relevant data will allow

(Continued on page 15)

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REPORT

FOR *Illinois Physicians*

MEDICARE PART B COMPARATIVE PERFORMANCE REPORTS

Illinois sends Comparative Performance Reports March 25, 1994.

Section 6102 of the 1989 Omnibus Reconciliation Act (OBRA) requires Medicare Part B carriers to profile physician billing patterns within each payment area or locality, and to provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality. The requirements of this legislation are met through the Comparative Performance Report (CPR) program. There is no overt action by the Medicare Carrier other than to inform the physician of these profile differences.

Utilization norms are calculated by determining the average number of services billed per 100 beneficiaries treated. Physicians who significantly exceeded the peer group norms (a peer group consists of physicians of the same specialty practicing in the same locality) were sent a CPR describing the procedures or services that were billed at a higher rate than their peers and, also, to what extent they exceeded the group norms.

The recipients of CPRs were encouraged (not required) to conduct an independent assessment of their utilization, coding and billing practices, and if appropriate, change their practice patterns to be more reflective of the peer group norm.

The Illinois Medicare Part B carrier mailed CPRs to 152 physicians on March 25, 1994. 41 telephone calls concerning these reports have been received as of April 15, 1994. The majority of the calls (83%) concerned incorrect specialty designations, sub-specialty issues and billing errors. The balance involved explainable over utilization (12%) and aberrant over utilization (5%).

Carrier personnel worked with physicians in the resolution of billing and specialty issues. From the carrier's perspective, the results of this program has been worthwhile and well received by the majority of physicians who contacted the carrier.

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EDITORIAL

Blowing away the smoke screen

Medical societies from 50 states, including ISMS, specialty societies and the AMA told federal lawmakers in mid-May that the five largest U.S. insurance companies are misinforming and misleading the public about antitrust legislation currently before Congress.

These insurance companies are trying to prevent physicians from forming health plans that would give patients more choices. They want to perpetuate a monopoly that is not in patients' best interests and that may jeopardize quality of care. We need antitrust relief so that we can be at the table when decisions about patient care are made.

The insurance industry is hiding behind accusations that antitrust relief would allow physicians to restrict the services of other kinds of health care providers. Yet these same insurance companies have blocked laws that would protect providers from being excluded from insurance company networks.

Organized medicine sent a letter to every member of Congress, telling them that insurance companies, which are exempt from antitrust laws, are participating in a "misinformation campaign" to deny other groups the right to compete. In the letter, we also told them about a statistic from a recent study by the California Medical Association – up to 31 percent of health insurance premium dollars are spent on administrative

expenses and insurance company profits.

Physician-run health plans would spend less on administration and more on patients. But to allow for the development and operation of such health plans, antitrust laws must be clarified and changed.

To help do just that, the AMA also published an advertisement in the *Washington Post* attacking insurers' opposition to antitrust reforms as a part of health system reform. The headline on the ad reads "What are they afraid of?"

This is more than just a theoretical issue; it is a real one that may potentially affect all physicians, and it is addressed in the Hatch-Archer bill (S. 1658, H.R. 3486), which provides antitrust relief for physicians. The insurance companies maintain that the bill would allow physicians to participate in price fixing, boycotts and other coercive activities. The truth is that under the bill, these activities would remain illegal and would be subject to civil and criminal enforcement.

Co-sponsoring the bill are more than 100 members of Congress including Reps. Thomas Ewing (R-Bloomington), Donald Manzullo (R-Rockford) and George Sangmeister (D-Joliet). However, we can't stop driving this issue, especially in light of the insurance industry's attacks. Our professional unity is essential. Contact your senators and representatives and urge support of this bill.

PRESIDENT'S LETTER

If you don't stand for something, you'll fall for anything

Alan M. Roman, MD



Perhaps you saw it, too – outrageous TV and newspaper accounts of a Naperville woman who left her 2½-year-old daughter in a locked car for more than eight hours while she gambled on a riverboat. Not so surprising, in light of this, was that while on the riverboat, she was arrested after allegedly taking gambling chips from other patrons. Or maybe you will recall the Addison couple that pleaded guilty to child endangerment and reckless conduct stemming from an incident in which they shackled their 8-year-old son to a bed on Christmas Day, while they partied at a relative's house, as punishment for the son's opening his presents too early in the morning. Or the scheme dreamed up by a Chicago fourth-grader to falsely accuse a teacher she disliked of sexual abuse because he insisted on discipline in his classroom.

These sensationalistic anecdotes will evoke feelings of surprise, sorrow and perhaps even shock from readers. But aside from their being interesting reading, these accounts say a lot about their subjects' values, just as when you read them, your emotions say a lot about yours.

Values are closely held beliefs that we support with thoughts, words, feelings and actions. Values are a sound set of beliefs that guide our actions. A melange of experiences melded over time, values include the worth of character, the influence of example, the dignity of simplicity and the power of obligation. Our value is the sum of our values.

People behave in a certain way because they want to, and each and every one of us keeps pace with a drummer that only we can hear. Newspaper accounts suggested that the parents in the examples above lacked self-discipline. I felt then, as I do now, that it was more a failure of the parents to develop a sound sense of values,

which as most of us know, is no easy task. Certainly the failure of self-discipline lies at the epicenter of many of life's most miserable moments, but that reveals a more fundamental problem, which is the poverty of values that confronts us today. Remember, the height of your accomplishments will equal the depth of your convictions.

Values are the foundation of our character and our confidence.

When you know what your values are, making decisions becomes easier. Pity the person who knows not what he or she stands for or believes in, for this person drifts aimlessly and will never enjoy true happiness or inner peace. Physicians are characterized by high ethical standards and principles of conduct and are fully capable of making decisions based on their own inner-directed value system. We are

never too old to learn or too young to teach.

Think then for a moment this day about your values. Think about what you believe in, what you stand for and what puts meaning into your life. Think, too, about what makes your life complete. Rather than waiting for someone else to offer direction, decide today what principles and values you wish to live by and make them vibrant guideposts on the walkway of life.

It is time for us, as doctors and as a profession, to closely examine our beliefs, not only for what we can glean about the consequences of our professional training, but also as much for what they say about who we are. Values are the glue that holds life's fabric together. Nothing speaks more loudly to a child than a parent's quiet example. Your actions and words reflect the values you possess. Commit yourself this day to living what you value and transform your values into guiding principles for everything you say and do.

*Make values vibrant
 guideposts on the
 walkway of life.*

POINT

The false issue of malpractice costs

By Robert A. Clifford

The following is reprinted with the author's permission from the May 10 issue of the Wall Street Journal.

In an April 13 Rule of Law column – “How Come No One’s Talking About This Health Reform?” – former Vice President Dan Quayle says that skyrocketing medical malpractice litigation and the threat of such litigation on doctors’ rising malpractice-insurance expenses have significantly increased the country’s health care costs. Yet all of Mr. Quayle’s figures cannot provide an explanation for hospital expenses in Indiana, a state that has enacted several of his suggested reform measures, which are greater than in states that have not enacted those so-called reforms.

For instance, in Indianapolis, average hospital expenses per inpatient day are \$1,078, while in Chicago, in a state without the drastic measures Mr. Quayle advocates, that same hospital stay is \$1,000, according to statistics from the American Hospital Association. That’s \$78 more per day in Indiana.

Mr. Quayle touts Indiana’s damage caps, which have been in place for 20 years. Yet they have not had any effect on health care spending in that state, which is consistently ranked 32nd in the nation. Objective studies have demonstrated that malpractice litigation and health care costs have little to do with each other.

Mr. Quayle decries “defensive medicine” and cites doctors who say they conducted unnecessary testing out of a fear of being slapped with a lawsuit. One would have to question those doctors’ ability as well as judgment. A surgeon driven by fear, and not knowledge, can be a dangerous thing. Interviews, in

fact, have shown most tests would have been conducted anyway in the name of quality care.

Mr. Quayle neglects to mention a feasible explanation for this abundance of testing: the self-referral scheme that adds an estimated \$10 billion to \$20 billion each year to the medical care tab. A report by the Consumer Federation of America found that physicians who have profit incentives stemming from ownership or investment in such facilities order 34 percent to 96 percent more diagnostic studies than those doctors who do not.

Mr. Quayle instead focuses on the false issue of rising malpractice premiums. Perhaps insurance companies’ profits should be examined instead. For instance, the Illinois [State Medical] Inter-Insurance Exchange, the largest insurer of doctors in the state, has boasted 10 years of a growing asset base and increased dividends.

The focus should not be on lowering premiums for the very people who cause the harm – the negligent doctors. A five-year study of malpractice in New York state conducted by Harvard Medical School found that negligent medical treatment had injured some 27,000 patients. About 7,000 people died of their injuries inflicted in hospitals each year. In other words, their deaths could have been avoided. Even more disturbing was the finding that up to 90 percent of these errors were preventable.

Rules governing doctors’ behavior and punishment should be stricter. Perhaps increasing the insurance premiums of chronically negligent doctors may be a deterrent.

Clifford is a partner in the Chicago law firm Corboy, Demetrio, Clifford.

COUNTERPOINT

The truth about medical malpractice costs

By Alan M. Roman, MD

Attorney Robert A. Clifford’s May 10 letter (“The False Issue of Malpractice Costs”) continues the trial lawyers’ organized campaign to introduce their own false issues and divert proper blame from the lawsuit industry for its role as a leading accelerant of medical costs. In so doing, he offers inaccurate data and reaches far-fetched conclusions regarding our own Illinois State Medical Inter-Insurance Exchange.

Mr. Clifford suggests malpractice insurance company profits are to blame for rising health care costs. If that’s the case, ISMIE certainly isn’t a good example. Public documents on file with the Illinois Department of Insurance show that ISMIE suffered a net loss of \$8.2 million in 1993, and that was after investment income and taxes.

ISMIE paid out \$1.27 in expenses and indemnity awards for every \$1 of premiums it took in last year. ISMIE was created by Illinois physicians as a service for physicians when insurers abandoned Illinois because it was impossible to make money in our state’s oppressive legal climate. If ISMIE has shown what Mr. Clifford calls a “growing asset base,” it is because it insures more physicians than it did 10 years ago and must therefore maintain the financial stability to satisfy state regulations and protect the truly injured patients who depend on its funds. (By the way, Mr. Clifford, ISMIE’s total asset base actually shrank by \$7 million last year.)

Health care costs relate directly to malpractice litigation. Lawsuit reform cuts costs. In California, which enacted a \$250,000 limit on noneconomic damage awards, physician insurance premiums rose just 5.2 percent from 1981 to 1988. In Colorado, with the same \$250,000 noneconomic award limit, physician premiums are 80 percent of what they were in 1988.

“Unnecessary” medical testing is driven by physicians’ need to protect themselves from unfounded legal action if a patient thinks he or she had a bad result and could win a huge jury award. This “defensive medicine” adds \$15 billion a year or more to the national health care bill. Such spending is not driven by physician self-referral, as Mr. Clifford

claims. Improper self-referral has already been declared unethical by the medical profession, and self-referral is regulated by Illinois and 24 other states.

Surgeons and other physicians do not practice in fear, as Mr. Clifford suggests, but rather in the full knowledge that any test unordered or any procedure unperformed could be grasped by an opportunistic plaintiff’s attorney as if it were a multimillion dollar lottery ticket. Physicians defend themselves successfully in court about 80 percent of the time, but each time, it costs thousands of dollars that could be better spent on care for people in need. ISMIE – just one physician-run company insuring doctors in one state – spent more than \$51 million in legal and other expenses last year just to defend claims against physicians.

Research by the Illinois Health Care Cost Containment Council indicates the cost of a day in a Chicago hospital is closer to \$1,908, not \$1,000, as Mr. Clifford claims. In any event, his comparison of daily hospital charges in Chicago and Indianapolis is irrelevant. Hospital charges do not fully reflect physician services, wherein the wasteful costs brought on by the legal system fall most heavily. Many physician services are provided outside the hospital.

The Harvard study noted by Mr. Clifford demonstrates nothing so much as the need for meaningful lawsuit reform. The truly injured sometimes go uncompensated while claims for lottery-type awards clog the court system. The only sensible solution is to continue providing the truly injured with full recovery of their tangible economic losses, such as lost wages and medical expenses related to the injury, while limiting the impossible-to-quantify, intangible “pain and suffering” awards to a reasonable \$250,000. This will cut down on the meritless suits by ending the vision of huge lottery-type awards.

Health care reform cannot succeed without meaningful lawsuit reform, which will go right to the heart of the problem: escalating costs forced by a legal system threatening to become no longer the servant of society but its master.

Dr. Roman is president of ISMS and a Flossmoor general surgeon.

LETTERS

In-flight Good Samaritans

I read with interest Dr. Robert Hilker’s letter in your May 6 issue, wherein he described a recent in-flight emergency experience and his concerns about malpractice liability.

At United Airlines, where I am corporate medical director, several hundred physicians per year volunteer as Good Samaritans in response to emergency situations aboard our aircraft. We are unaware of any pending, actual or threatened liability actions by patients or family who have been thus attended. Perhaps that is because of the unique situation, or perhaps because of the cooperative efforts between operational and medical personnel and the lack of alternatives. In any case, upon mandating the use of more extensive medical kits

on aircraft in the 1980s, the Federal Aviation Administration contended that state Good Samaritan statutes would apply in airspace as well as on the ground.

Per the author’s suggestions, it is indeed good advice to request the emergency kit at the onset of the emergency and ask for other physicians or paramedical personnel as appropriate. Our in-flight staff is required to ask for proof of physician licensure, and I am sure Dr. Hilker can understand the pro forma need for such a request and be comforted by the fact that, in an actual emergency, such niceties are bypassed and good judgment prevails.

Perhaps our desires and abilities to act as Good Samaritans are in reality not much different in the air than on the ground.

— Gary M. Kohn, MD
Chicago



“That ‘CTS’ from my last position as office manager isn’t a degree, it’s carpal tunnel syndrome from typing insurance forms.”

Overcoming
'difficult'
doctor-patient
relationships

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ISMIE Update

Don't forget
your premium
payment

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Physician action critical to secure tort reform

LEGISLATION: Chicago surgeons hear about the importance of doctor participation in the political process. By Anna Chapman

[CHICAGO] A cap on noneconomic damages in malpractice suits is the only real tort reform that will make a difference for Illinois physicians, said Harold Jensen, MD, chairman of the ISMIE Board of Governors, in an April 30 presentation to the Metropolitan Chicago Chapter of the American College of Surgeons. Joining Dr. Jensen was ISMS President Alan M. Roman, MD, and House Republican Leader Lee Daniels (R-Addison), who provided an update on the status of caps legislation in Illinois and the role physicians can play in achieving significant tort reform.

Dr. Jensen said ISMS and ISMIE are working together to secure a \$250,000 cap on noneconomic awards, such as

damages for pain and suffering. But individual physicians must be diligent and organized to achieve legislative changes in the tort system, because trial lawyers claim there is no liability crisis, Dr. Jensen explained. He described physicians' work in obtaining tort reform in 1985, when 4,000 physicians traveled to Springfield to lobby for change.

Dr. Jensen refuted the belief among some legislators and trial lawyers that a cap is unnecessary and that ISMIE generates large profits. "There is no profit," he said, noting that in 1993, ISMIE's premium rates accounted for only 76 percent of expected payouts, and investment income paid the other 24 percent. ISMIE reserves are ear-

marked to cover pending suits, he added.

Trial lawyers contribute to the skyrocketing costs of litigation, Dr. Jensen continued. "In 1992, trial lawyers received one-third of ISMIE indemnity payouts."

Whether caps legislation will be passed by the General Assembly and signed by the governor hinges on the outcome of the November general election, Dr. Jensen said. "Medicine has a strong friend in the governor's mansion who needs your support."

Dr. Roman agreed, adding that physicians must become players in the political process. "I can't stress enough the importance of grass-roots involvement. When you know who your legislators are and



During a meeting of Chicago surgeons in April, Dr. Roman (left), Daniels (center) and Dr. Jensen discuss the likelihood of passage of a cap on noneconomic damages in the General Assembly.

where they stand, it makes it a lot easier to establish relationships now, so that your representatives and your senators are there when you need them.

"We need to have some strategy we can all agree on," Dr. Roman continued. "We're not entering this struggle alone. We have a lot of friends, including those among the Illinois public. Polls show that citizens have had enough and that caps are a reasonable solution."

Daniels said that it will be difficult to pass a cap this year.

However, he noted the impact of physicians' efforts to enact tort reform in 1985. Another organized effort is especially critical because tort reform opponents are more prepared than in the past, he said.

Physicians must work hard to have their voices heard in Springfield, since tort reform is just one of many pressing concerns legislators must address, including Medicaid reform, the education system, criminal justice issues and riverboat gambling, Daniels added. ■

MALPRACTICE ROUNDUP

Court rules mono misdiagnosis does not constitute malpractice

A physician was not negligent in treating a patient for mononucleosis, even though the patient presented with symptoms that some experts said could have indicated serious neurological problems, according to a case summary in the *Malpractice Reporter*.

The patient went to the clinic at the State University of New York at Binghamton complaining of a persistent, throbbing headache. His blood pressure and temperature were normal, but his lymph glands were swollen and he had lost 16 pounds. He told the examining nurse that he had been diagnosed with sinusitis 10 days earlier at the emergency room of a private hospital. He said erythromycin had been prescribed.

After the nurse's preliminary exam, the clinic's medical director examined the patient. In addition to the swollen glands and headaches, the patient had suffered bouts of vomiting, which the physician attributed to a reaction to the erythromycin. Because the vomiting had subsided and the patient's appetite had improved, the physician said the symptoms were more consistent with mono than with sinusitis and ordered a blood test. He also prescribed additional erythromycin for any residual sinusitis and released the patient without ordering a neurological exam. The patient died the next day from an intracerebral abscess in the frontal lobe of his brain.

At trial, the plaintiff argued that the physician was negligent because he should have recognized the serious nature of the patient's illness, ordered more tests and hospitalized the patient immediately. But the trial court — sitting without a jury — dismissed the claim.

The appeals court upheld the lower court's finding that the patient did not appear to be seriously ill when treatment was delivered, since his symptoms had improved and he showed no evidence of dizziness, slurred speech or neurological problems. Despite conflicting medical testimony about the appropriateness of the defendant-physician's actions, the court ruled that failure to order emergency blood tests and perform a neurological exam and a diagnosis of mono did not constitute malpractice. ■

Couple wins damages in false HIV diagnosis suit

A couple was awarded \$125,000 in a malpractice lawsuit involving a false HIV diagnosis, according to an article in *New Jersey Medicine*. In the case, a pregnant patient and her husband — both of whom are Roman Catholic — were told she was HIV-positive after a blood sample from her blood pregnancy test was accidentally switched with the sample of an HIV-positive patient. The couple was advised to abort the pregnancy because of the diagnosis.

Although the couple learned 10 days later that the initial diagnosis was inaccurate and the patient ultimately delivered a healthy baby, she filed a malpractice suit against the hospital and staff. The plaintiffs said that as a result of the incident, they suffered from post-traumatic stress disorder, which resulted in phobias about illness and doctors and a severe emotional reaction to the conflict between religious doctrine and medical advice.

After hearing testimony from a psychologist who said the woman would continue suffering the effects of post-traumatic stress disorder, the jury awarded her \$100,000 and her husband \$25,000. The defense had contended that anger, not post-traumatic stress disorder, was at issue in the trial. ■

Overcoming 'difficult' doctor-patient relationships

RISK MANAGEMENT: To help avoid litigation, physicians should analyze their communication with patients. By Anna Chapman

[OAK BROOK] Problematic doctor-patient relationships can lead to malpractice suits unless physicians recognize that the relationship – not the patient – is difficult, according to lecturers at a new ISMIE workshop held May 11 in Oak Brook. The seminar was also offered in Springfield on May 12.

The program, "Difficult' Physician-Patient Relationships," was designed to help physicians understand that difficult situations occur because patients and physicians contribute to a communication lapse, said Maysel Kemp White, PhD, a consultant with the Miles Institute for Health Care Communication, which developed the workshop.

"Our mission is to improve communication skills between physicians and patients," White said. "The main thing we're trying to teach is that if we look at these relationships in the context of relationships, we have opportunities for change. If physicians look at themselves as victims of difficult patients, there is no opportunity for change."

Although the most difficult relationships occur with only about 20 percent of patients, physicians can take steps to ensure smoother communications with all their patients, White said.

When problems arise, physicians should change the way they communicate with patients, according to Catherine McGinness, MD, a Chicago family physician and workshop facilitator. Doctors may also be able to convince patients to alter their approach to the situation by showing patients that they are willing to listen and perhaps make changes in the treatment plan, she said.

COMMUNICATION BARRIERS occur under many circumstances, such as when the expectations of the doctor and the patient differ and both parties are inflexible, the lecturers said. Lack of a successful diagnosis and cure may also contribute to ineffective physician-patient relationships, they said.

Offering examples of difficult relationships, program attendees listed encounters with patients who fail to take responsibility for their health care or are hostile or too talkative, or those who visit the doctor for comfort, not actual treatment.

White explained that what one physician perceives as a difficult situation, another doctor may not find troublesome. To illustrate that point, the facilitators showed participants several simulated videotaped case histories and asked them to select the difficult cases. Among the examples shown were a patient who didn't speak English, a man who claimed his obesity was caused by "fat genes" and a woman who was afraid to undress for a routine physical. Participants' choices varied as to which situations were difficult.

Physicians may use a wide range of

techniques to bridge communication gaps with their patients, said Frederic Platt, MD, a Denver internist and workshop facilitator. Lecturers at the seminar helped physicians determine which technique to use in a given situation. The techniques are

- Acknowledging the existence of a problem,
- Establishing boundaries,
- Demonstrating compassion,
- Discovering the meaning of the visit and
- Extending the health care system to include others.

To acknowledge the existence of a problem, physicians should address their own feelings about situations and explain their perception of the problem to patients, Dr. Platt said. "It helps to acknowledge that you are having an emotional reaction," he explained, adding that physicians should not blame the patient.

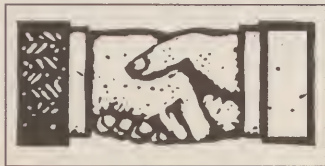
Physicians sometimes fail to set boundaries for the interaction, such as the content and length of the discussion, Dr. Platt said. Asking patients directly what they hope to accomplish during their visit helps to clarify physician and patient roles, he added. In addition, Dr. Platt recommended that physicians explain to patients what they need from them to ensure effective communication. For instance, if a physician is uncomfortable that a patient is standing during a conversation, he or she should ask the patient to sit down.

Compassion and understanding are also important, Dr. Platt said. "When we're in trouble, we tend to start explaining more and more, when what we really need is to understand." Showing compassion may be as simple as offering the patient a cup of coffee, he said.

Discovering the meaning of the visit is essential to good communication and effective treatment, Dr. Platt noted. "Don't be the doctor who knows before he asks." Physicians must elicit patients' concerns, he said. "To discover an appropriate course of action, physicians must negotiate with patients to find a joint plan."

In some cases, physicians will have to include other professionals or resources to improve communication, such as other physicians, social workers or even friends and family, Dr. Platt said. When collaborating with other professionals, physicians should clearly explain whether they are asking for someone's opinion or turning the case over to them. Miscommunication between providers could lead to lapses in patient care and possible liability, he noted.

"The most important thing physicians can get out of the seminar may be a willingness to pause and consider what's going on when things aren't going well," Dr. Platt explained. "The new step is to stop and consider doing something different." ■



Don't forget your premium payment

Notices about premium payments were recently sent to all ISMIE policyholders. Quarterly payments are due on July 1, and if payment has not been received by that date, a warning of cancellation will be mailed.

If payment has still not been received by July 19, the policy will be canceled, and all certificate-holders on record, such as hospitals, will be notified. At that point, to reinstate a policy, payment must be received and processed by July 29.

Policyholders should allow seven working days for mailing and processing their premium payment. For more information, contact the ISMIE underwriting division at (312) 782-2749 or (800) 782-4767. ■

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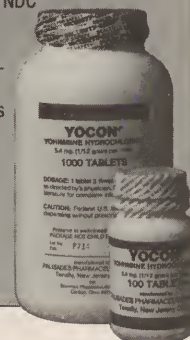
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PROFILE

Tackling the challenges of medicine's future

ISMS' new president vows to communicate with members and the public on vital issues.

BY KATHLEEN FURORE

If it hadn't been for a junior high research project and the *World Book Encyclopedia*, Alan M. Roman, MD, might have ended up in a courtroom instead of an operating room. "In seventh grade, I had to do a term paper on what I wanted to do with my future. I looked at real estate because my dad was a Realtor; I looked at medicine because it sounded interesting, with its problem-solving and all the technical gadgets; and I looked at law. What probably drove me into medicine more than anything else was the fact that, faced with no time to get the project done, I went to the *World Book Encyclopedia* and found a longer section on law than on medicine," recalled Dr. Roman, ISMS' new president and a general and peripheral vascular surgeon at St. Francis Hospital & Health Center in Blue Island. "So I did the paper on law, and it was so boring and so uninteresting that from that time forward, any thought I had of being an attorney went by the wayside."

What didn't change, though, was his interest in medicine. Searching for a summer job before his senior year in high school, Dr. Roman – who was born in Chicago and later moved to the southern suburbs – read a *Chicago Tribune* magazine feature describing the wide range of opportunities in the health care field. "Operating room tech" caught his eye. Despite the skepticism of his parents, who suggested he be a little more pragmatic, he applied to four Chicago-area hospitals for a position as an OR tech. St. Francis hired and trained him, and for the next six summers, Dr. Roman worked in the operating room, handing instruments to surgeons.

"I became interested in the surgical part of medicine as a result of that *Tribune* article and my experience as an OR tech. The OR was kind of fascinating to a fellow growing up. I remember going to the medical bookstore across from Cook County Hospital and buying an anatomy book. I brought it home, and my mom said,

'You're never going to learn that.' But I was pretty enthusiastic. It became a challenge to learn and do well."

Dr. Roman has been tackling challenges ever since. He graduated from Northwestern University and the University of Health Sciences/Chicago Medical School, completed his general surgery residency at the University of Minnesota/Mayo Graduate School of Medicine in Rochester and served as an associate staff member of the Mayo Graduate School of Medicine and Mayo Foundation. He joined St. Francis' medical staff in 1980 and soon after became actively involved in organized medicine through a chance encounter with Harold Jensen, MD, who now serves as chairman of the ISMIE Board of Governors.

"When I moved to Flossmoor, I decided to get involved with the zoning board. There was a meeting about a petition to build a community center in the middle of a development of town homes, and Harold Jensen – who lived in one of them – came to the meeting. He noticed the MD on my nameplate, came up to me afterwards and suggested I get involved in organized medicine. I asked, 'How do I do that?' and he told me to come to one of the branch meetings of the Chicago Medical Society. I took him up on that and went from there."

Dr. Roman has hit many milestones on his



Photos by John McNulty

PROFILE



I want to reach out to members to help them realize the Society is looking out for their best interests and trying to make sure the changes that are crafted are what's best for patients and the practice of medicine.

journey from new CMS member to ISMS president. The immediate-past president of CMS, he has served on several committees at CMS and ISMS and has been actively involved with ISMIE, IMPAC and the ISMS Washington Presence program. Dr. Roman is also active outside of organized medicine. He chairs the public affairs committee of the Illinois Division of the American Cancer Society,

is a member of the Flossmoor Plan Commission and serves as vice chairman of Flossmoor's Zoning Board of Appeals. And until last year, he was a medical commentator on WMAQ 670 AM.

Family also plays an important role in his life. He lives in Flossmoor with his wife, Lin, 7-year-old son, Justin, and 3-year-old daughter, Lindsay.

Dr. Roman said he believes the leadership positions he has held will help him meet the biggest challenge he'll face in the coming year: communicating with ISMS' 18,000 physician members as personally as possible.

"While it's easy to communicate with members as a whole through the pages of *Illinois Medicine* or through their elected representatives, the challenge becomes communicating with them as if we were having a conversation over the backyard hedge," Dr. Roman said. "The problem is, there is so much information available and the pressures on physicians are so great. But that won't prevent me from trying to approach members on an individual basis. I want to communicate what is happening out there and how it is going to affect them, to get them energized and motivated to do the things they need to do to protect their practices and preserve the practice of medicine as we know it." To facilitate that communication, Dr. Roman said he will "talk to any member at any time" and promises to return all calls placed to him at the medical society.

PHYSICIAN ANTITRUST RELIEF and tort reform will be the key issues addressed during his presidential tenure, Dr. Roman said. To accomplish those goals, physicians must be involved at every level of the health care reform debate, he added.

Citing a frequent message of ISMS' immediate-past President Arthur Traugott, MD, Dr. Roman said significant cost containment can be achieved only if it includes medical malpractice reform, namely a cap on noneconomic damage awards. "The Illinois State Medical Society has worked hard at explaining these issues not only to legislators but to the public as well. But we have a lot of work left to do. Medicine has to be able to identify, support and elect those individuals who are critical to giving us the majority we need to create the



mitments. Yet that is one of the facts being dictated by the changing medical landscape. Physicians are problem-solvers, and the same talents and abilities that have led them to be successful in the practice of medicine lend themselves to the political and business realms.

"As president, I want to reach out to members to help them realize the Society is looking out for their best interests and trying to make sure the changes that are crafted are what's best for patients and the practice of medicine."

Dr. Roman said that ISMS is assisting members through the Washington Presence program, the Health Reform: Taking Charge of Change program and the soon-to-begin Membership Briefing Initiative, which will update physicians about the status of health care reform in Washington. These efforts have "empowered physicians to be recognized as leaders in their communities and have involved physicians and patients in the health care reform debate," he noted.

In addition to his commitment to communicate with members, Dr. Roman said he will work at increasing the Society's visibility by sharing physicians' concerns and interests with the public. "During the first month of my presidency, the Illinois State Medical Society received a tremendous amount of media attention regarding the House of Delegates' decision to oppose the Clinton health care reform plan, the HIV issue and the Gacy execution. We can't be up front every day, or pretty soon our message will get tired. But I haven't passed up any media opportunities, and I'll make an attempt this year to elevate another issue and bring it forward every few weeks. I'll try very hard during my presidential year to help ISMS have a heightened presence in the media." ■

changes we've been working so hard to craft."

Although he said physicians are understandably frustrated with increasing pressures, responsibilities and costs, Dr. Roman stressed that doctors must become "multidimensional" to respond to changes occurring in the profession. ISMS, under his leadership, will continue working on programs and services that will enable physicians not only to survive but to thrive in the health care marketplace of the future, he said.

"It's so hard to convince physicians they need to be politicians and businesspeople, because they're already trying to balance the responsibilities of their practices with their personal lives, families and myriad other com-



ISMS House of Delegates addresses physician issues

Physician leaders vote to oppose the president's reform proposal.
By Anna Chapman and Lynn Koslowsky

Clinton plan

The House heard significant debate regarding the Society's position on President Clinton's Health Security Act. Ultimately, delegates adopted one of two resolutions to oppose the plan in its current form. Delegates testifying on the House floor argued in favor of opposing the whole Clinton proposal instead of only certain elements.

Opponents of the resolution noted that groups like the AMA have never come out against an entire plan and have successfully lobbied to eliminate anti-medicine provisions from reform proposals. Supporters of the resolution said that opposing the plan in its current form would still allow the Society to support a sufficiently changed plan.

The adopted resolution also directs ISMS to introduce a similar resolution to the AMA House of Delegates.

Definitions

The House adopted two resolutions introduced by the Peoria Medical Society to clarify certain terms used in the discussion of health system reform. Because the terms "universal access" and "universal coverage" are often used interchangeably, ISMS will submit a resolution to the AMA asking for standard definitions of both terms.

After hearing physician testimony on the resolution introduced by John Taraska, MD, the reference committee determined that universal access refers to individuals' ability to obtain medical care, regardless of their insurance coverage. Universal coverage refers only to the availability of health insurance coverage, regardless of the ability to obtain care. As requested by the House, ISMS will also ask the AMA to "explore in-depth the ramifications of both universal coverage and universal access on the economy of this country, on health care delivery, on our patients and on physicians."

The reference committee also discussed the term "managed competition," saying

that it "may mean different things to different people." The House adopted a resolution stipulating that ISMS urge the AMA to provide a precise definition of managed competition and that the definition be disseminated to all parties interested in health system reform.

Dues

Delegates participated in an extensive reference committee debate about ISMS' dues level. M. LeRoy Sprang, MD, chairman of the Society's Finance and Medical Benevolence Committee, narrated a slide presentation illustrating ISMS' financial status and current and future programs. He said that the last dues increase was approved in 1987 as part of a three-year plan and that the dues level was maintained by extending that plan for three more years. But for the last two years, that plan has resulted in a deficit and has required use of permanent reserves, he noted.

Finance committee members said that the committee and the Board of Trustees have carefully monitored the Society's financial activities and explored all options to use resources efficiently. However, more funds are needed to maintain core programs and to develop new programs and services related to the changing health care environment.

A resolution introduced by ISMS Secretary-treasurer David Littman, MD, for the Board of Trustees, proposed a dues increase of \$149. In reference committee, delegates discussed the possibility of higher, lower or incremental increases. Most delegates concurred that the \$149 increase was necessary and was the appropriate amount.

During the debate in the House of Delegates, however, a motion was introduced to set the dues increase at \$75. Related discussion centered on the prospect of prioritizing and eliminating critical programs, and the motion was defeated.

The dues increase of \$149 was ultimately overwhelmingly adopted by the House.

(Continued on page 12)



Henry Tabe, MD, a Cook County delegate, debates an issue on the House floor.

Matt Ferguson

Foundation executive analyzes state of health care debate

ACCESS: Physicians hear about consumers' concerns and proposals for reform. By Kathleen Furore

[OAK BROOK] At the ISMS Public Affairs breakfast on April 23, Stuart Butler, PhD, — vice president and director of domestic and economic policy studies for the Heritage Foundation — addressed consumers' concerns about key features of most health care reform proposals currently being debated. He also discussed possible approaches that would allay consumers' fears and help remedy problems with access and health care delivery.

Butler authored the Heritage Foundation's Consumer Choice Health Plan, which was introduced in Congress in late 1993 by Sen. Don Nickles (R-Okla.) and Rep. Cliff Stearns (R-Fla.) and co-sponsored by one-fourth of the Senate and House Republican leadership. He has also been a leading proponent of reducing government intervention in medical financing and decision-making.

"It isn't Whitewater but the central elements [of the proposals] that are causing widespread anxieties," Butler said. Specifically, he noted that health care consumers are deeply concerned about possible employer mandates, health alliances, the role of insurance companies and a standardized benefits package "set by some commission in Washington. Most Americans are satisfied with their care and insurance coverage. They're worried they'll lose [what they have] and are concerned about security," he explained, adding that people are most worried that they'll have no access to affordable health insurance if they leave their jobs or lose them.

The portability problem exists because employees don't own their health insurance and the current tax system makes it difficult for individuals to buy affordable coverage, according to Butler. Remedies in the Nickles-Stearns bill include allowing people to buy their own plans through organizations such as unions and churches; preventing insurance companies from dropping patients who lose their jobs or become seriously ill or denying coverage for pre-existing conditions; and changing the



Butler

Matt Ferguson

way the system provides tax relief and subsidies, he said. Nickles-Stearns calls for tax credits that would let individuals claim a sliding-scale credit for any health plan they selected, as well as for out-of-pocket expenses and contributions to a medical savings account, Butler explained. If the credit exceeded the family's tax liability, the government would refund the difference. That would be a "big inducement to obtain coverage," since people with low incomes could receive a refund of \$2,000 or more, he added.

In light of mounting concerns about health care reform and the snags President Clinton's plan has hit on Capitol Hill, Butler said the time is right for physicians to wield their influence by making their feelings known. "If there is any time to impact the debate it's now, as anxiety rises," Butler said. "There is a move in Congress to move back major structural reform; the mood in Congress is, 'Let the states handle it.' So it's wise to focus your efforts at the state level, although you should keep pushing at the federal level, too." Any changes that occur this year will likely deal with insurance and will probably focus on pre-existing condition limitations and portability, he said. "This is simply round one in major reform in the health care system." ■



Newly installed ISMS Alliance President Carolyn Kobler (left), of Rockford, thanks immediate-past President Mindy Chadwick, of Decatur, for the time and energy she devoted to Alliance programs during her tenure.

Matt Ferguson

Children suffer from effects of violence

TRAUMA: The harm to children from exposure to violence is increasing. By Tamara Strom

[OAK BROOK] Thirty-five percent of the children living in some urban neighborhoods in the United States will see a homicide before their 15th birthday, according to James Garbarino, PhD, a world-renowned expert on child abuse prevention and social policy. That makes those communities seem more like a "war zone than a society at rest," he said during an April 21 presentation to the ISMS Alliance House of Delegates.

"Even kids who don't live in violent areas are affected by [violence]," he said. "Our children are living in an increasingly socially toxic environment."

Over the past 10 years, Garbarino has traveled around the world to see how children deal with the chronic effects of living with war.

ANNUAL MEETING WRAP-UP

He has visited Mozambique, Cambodia, Northern Ireland, Croatia and Kuwait. But children have a greater chance of being injured by a violent action in some areas of the United States than in countries experiencing war within their borders, he said. "The odds of a kid living in Chicago getting killed are 15 times greater than a child living in Northern Ireland."

Violence is embedded in the consciousness of children, he said, noting that children show the effects of exposure to violence through trauma, post-traumatic stress and higher levels of aggression. School-age children are more likely to suffer psychological trauma from contact with violence, he said. "By age 8, patterns of aggression are well-established and predictive of adults who will be aggressive."

Children who witness violent acts or who are exposed to violent conflict over a long period are in a constant state of arousal caused by the stress and trauma of the situation, Garbarino said. As an example, he described the physical conditions of the children who survived the standoff last year at David Koresh's compound in Waco, Texas. Although they looked fine and appeared to be unharmed, the children were suffering the effects of trauma. Their heart rates were about 130; normal rates for children that age range between 60 and 70, he said.

And it's not only real violence that children see. "Kids are witnessing atrocities in movies and videos," he said, singling out the "Nightmare on Elm Street" movies featuring Freddie Krueger. Such movies are particularly frightening to children, because the character unleashing the violence enters the dreams of the characters on whom he preys. That makes it difficult for children to separate the fear in the film from reality, he said.

Violence in America is becoming a social phenomenon, Garbarino said. However, that is not all bad, he noted, because now that people see the proliferation of violence as a problem, society can address it. He likened that enlightenment to the injuries and deaths of children who were in car crashes several years ago. "It

wasn't until we connected this with speed limits and DUI that we put children in the backseat in car seats. Now, no baby ever leaves the hospital and gets into a car without being in a car seat."

Communities can take several actions

to combat violence, Garbarino said. For example, community policing and gun control help stem violent acts. In addition, communities should insist on smaller high schools so that teen-agers receive more individual attention, and they should begin dealing with domestic violence. "The most violent kids in the community are the ones who come from violent homes."

Parents should also start dialogues with their children at a young age and teach them that conflict need not lead to violence. "[Violence] is not just a problem of the inner cities or of minority groups. Every one of our kids is living with it; every one of our kids is absorbing it." ■



Garbarino

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Medicaid

(Continued from page 1)

addressing the Society's position on key components in the proposed Medicaid overhaul, Dr. Roman called the governor's plan a "good blueprint for achieving necessary reforms." The ISMS Board of Trustees supports in principle the "efforts of Gov. Edgar and IDPA to initiate Medicaid reform that more broadly incorporates and emphasizes managed care mechanisms and preserves quality," he noted. He also stressed the need to work with the administration and IDPA to create a flexible program that maximizes physician input and adaptability to patients' needs. The plan includes two delivery mechanisms – fee for service and a capitated managed care approach.

"Our goal is to support meaningful, positive change in the organization of Medicaid financing, which will help patients achieve access to quality health care," Dr. Roman explained. "ISMS also seeks to support measures to guarantee that the transition to a new system is accomplished in an orderly manner that respects the rights of patients and physicians and that offers protection against possible abuses."

Dr. Roman addressed the following areas as being of most concern to ISMS members:

- **Fee for service** – A managed care fee-for-service system should be continued under the new program. ISMS believes patients and physicians should be free to choose this option.
- **Freedom of choice** – Dr. Roman expressed the Society's support for allowing Medicaid recipients to choose between a fee-for-service system with managed care and an HMO or other managed care plan, while calling for the state to assign to a managed care plan only those individuals who fail to make a choice.
- **Patient empowerment** – Because patients need adequate information to

Medicaid HMO demonstration project slated

Just as state lawmakers were conducting markup sessions on Gov. Jim Edgar's proposal for overhauling the Medicaid system, the Illinois Department of Public Aid was set to begin a demonstration project to promote the enrollment of more Medicaid recipients in HMOs. IDPA designed the project, which is scheduled to start in early June, to try to improve access and control costs, according to an ISMS analyst.

Under the project, IDPA will ask Medicaid recipients who are eligible for the state's Healthy Moms/Healthy Kids program to select a primary care provider – a Healthy Moms/Healthy Kids-enrolled physician, a Federally Qualified Health Center or an HMO. All Healthy Moms/Healthy Kids-eligible recipients who fail to make a selection will automatically be assigned to an HMO, according to public aid documents. The

demonstration project will focus on Medicaid recipients who are scheduled for their annual face-to-face interview with public aid staff to determine whether they are eligible to continue receiving benefits, the documents stated.

Doctors who wish to maintain existing physician-patient relationships should talk to their Medicaid patients and let them know that they want this relationship to continue, because recipients who do not specify the name of a primary care physician will be assigned to an HMO, according to ISMS advisers. Doctors are encouraged to conduct these discussions with their patients continuously during the next year, since it is impossible to predict when individual patients are up for redetermination, Society advisers stressed.

To facilitate re-enrollment of patients with the physician of their choice, IDPA

will provide doctors with a specially designed card on which they can supply the name and address of their practice. Physicians should instruct their patients to give the card to the client education representative who conducts their redetermination-of-benefits interview, according to IDPA. Patients who present a card at the interview will automatically be reassigned to their current primary care physician, provided their doctor has not exceeded the number of patients he or she agreed to treat, IDPA said. In addition, physicians who want to continue treating Chicago recipients must be enrolled in Healthy Moms/Healthy Kids. To enroll, call IDPA at (217) 524-7311.

Physicians with questions about the demonstration project may contact the ISMS division of health care finance at (800) 782-ISMS or (312) 782-1654. ■

make educated decisions about health care plans, ISMS proposes providing Medicaid patients with complete written explanations of all options available to them. "ISMS also believes patients should have the ability to choose the site for provision of health care services within a managed care plan," Dr. Roman wrote.

- **Mental health "carve-outs"** – Although Dr. Roman noted that the concept of carving out mental health care is acceptable to ISMS, he cautioned that there are many practical implementation questions that must be addressed before finalizing any approach. "Carve outs" would allow mental health care to be handled separately from other health care services provided under managed care contracts.
- **Any willing provider** – Dr. Roman

expressed ISMS' concern that a system with more managed care could disrupt some existing physician-patient relationships. Consequently, ISMS strongly supports inclusion of all physicians who can meet the terms and conditions of the managed care entity and wish to treat Medicaid patients. "We believe the effects of this disruption can be minimized by requiring managed care plans to accept for the purposes of treating Medicaid patients any physician [who meets] the terms and conditions of the managed care plan." ISMS also supports language to ensure more physician participation in the program and greater choice to patients.

- **Reimbursement for emergency room services** – Since federal and state law requires hospitals and physicians to evaluate patients who seek care at emergency rooms to determine whether a true

emergency exists, Dr. Roman explained the importance of addressing reimbursement for ER services. "Logically, managed care plans will attempt to save money by controlling instances of inappropriate usage [of hospital emergency rooms]. ISMS believes it is important to specify that managed care plans must pay physicians and hospitals for these services that the law requires them to provide."

- **Quality assurance** – Dr. Roman observed that the state's experience in reviewing care provided under a fee-for-service system will differ under a capitated system. He emphasized the essential role of physician input in assuring quality of care: "It is imperative that the new system of review fully involve physicians in the review of care." ■

Annual Meeting

(Continued from page 10)

Employer mandate

New ISMS policy opposes employer mandates as a means of providing health insurance for employees.

The reference committee heard only favorable testimony on two resolutions opposing the use of employer mandates and noted in its report to the House that a mandate could prove costly to businesses, especially small businesses.

Subsequently, the House approved a resolution introduced by Edward Peterka, MD, a delegate for the Knox County Medical Society. The resolution also directs ISMS to submit to the AMA a resolution rejecting an employer mandate.

Freedom of choice

Favorable reference committee debate prompted delegates to voice a strong belief that patients should have freedom to choose their own physicians. Following minimal floor debate, the House adopted a resolution directing ISMS to petition the AMA to encourage true freedom of choice of physicians under any state or national health insurance plan. Vedantham Srinivasan, MD, of DuPage County, introduced the resolution.

Medical retirement accounts

At the 1993 ISMS Annual Meeting, dele-

gates voted to explore financing health care with medical retirement accounts. This year, the House adopted a resolution introduced by Sadiq Mohyuddin, MD, of the Madison County Medical Society, asking ISMS and the AMA to investigate further refinements to the MRA concept and to "publicize and promote the MRA concept as a third major area of emphasis, in addition to medical liability reform and antitrust reform, if appropriate."

In reference committee debate, physicians noted that MRAs – tax-free or tax-deferred accounts – offer individuals personal incentives to seek cost-effective care. MRAs could be coupled with catastrophic health insurance to provide complete coverage, physicians said.

Mission of ISMS

The changing health care environment was cited as a catalyst for a resolution recommending re-evaluation of ISMS' goals and missions. The resolution, sponsored by Raymond Dieter Jr., MD, for the DuPage County Medical Society, specified that this reassessment address antitrust, negotiation and representation for solo and group practitioners. In addition, the resolution expressed the need to reconsider the ancillary services provided and to ensure that they best meet the needs of physicians. There was little discussion of the resolution in reference committee, and

it was adopted by the House.

Unified membership

Delegates also raised the issue of unified membership between county medical societies, ISMS and the AMA. However, a resolution was defeated that would have removed requirements for unified membership from ISMS bylaws.

Another resolution dealing with unified membership was adopted by the House. The resolution, introduced by Edward Wojcik, MD, recommended setting up an ad hoc committee to study the issues surrounding de-unification senti-

ments and to report its findings to an AMA committee.

Unity with county medical societies

A resolution encouraging cooperation between ISMS and county medical societies was introduced by Mark Shima, MD, for the Peoria Medical Society. In reference committee, delegates said that the resolution reaffirmed current practice but that it was worthwhile to formalize the need for and practice of cooperation. The resolution was adopted by the House. ■

Raymond Dieter Jr., MD (below), testifies in reference committee. Henri Havalala, MD (far right), and James Milam, MD, participate in ISMS' congressional letter-writing campaign for antitrust relief.



Photos by Matt Ferguson

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Mental health

(Continued from page 1)

estimated 66 percent of those patients next year, Edgar said.

"We've become more aggressive in getting Medicaid dollars to community mental health providers," he said.

The governor added that he has proposed an overhaul of Illinois' Medicaid system and said he plans to carve out mental health services from any overall managed care plan that is adopted.

In conclusion, Edgar thanked the association members for their "help and input in chartering mental health reform. If I am honored with another term as your governor, you and I, together, will give Illinois one of the best mental health systems in America."

Netsch's presentation included a brief history of mental health care in Illinois, and a description of efforts she, as a state legislator, made to improve mental health services. Criticizing what she called Edgar's "stop-and-start approach to the mental health budget," Netsch offered general ideas for enhancing the system through increased funding and resource reallocation.

She noted that she was responsible for efforts to decriminalize alcoholism in Illinois in 1974, established a division of alcoholism in the mental health department and was instrumental in revising the mental health code in 1977. Although she credited Edgar with establishing the nonpartisan Mental Health Service System Advisory Council and making Illinois a "much friendlier place for the mentally ill than it was four years ago," Netsch said the administration's inability to tap federal Medicaid dollars and fund education is stifling continued mental health care reform in Illinois.

She said she will raise taxes to give education a guaranteed source of funding "so that every budget battle isn't over education." She added that in theory she supports carving out mental health to allow those services to be dealt with separately from others provided under Medicaid managed care contracts.

Netsch, however, hedged when asked how she would increase per capita spending for mental health. "That's a budget decision that takes place year after year," she said, adding that the state should shift more resources into community mental health facilities. "There's no sense for me at this moment to put a specific dollar figure on it." ■

Managed care

(Continued from page 3)

easy outcomes reporting and informed utilization management. We are actively pursuing short- and long-range projects to computerize our clinical information systems."

Dreyer is also collaborating and integrating with local hospitals, Dr. Shields noted. Rapid population growth in Dreyer's service area prompted the organization to develop primary care satellite offices, he said, adding that the clinic is reviewing participation in metropolitan marketing alliances.

In addition, the clinic has expanded its programs to adjust to changes in health care delivery, Dr. Shields said. These include a new surgicenter offering surgical procedures less expensively than hospitals and a mandatory formulary to control prescription drug costs. ■

UR legislation

(Continued from page 1)

the same specialty or field of medicine to evaluate and concur with the UR agent's determination to deny care when that determination is contrary to the recommendation of the patient's physician; and

- Establishes that UR agents are liable to patients for any injuries that occur due to an agent's decision to deny care against the treating physician's recommendations.

Lang and IHA were hesitant at first to accept ISMS' amendment, but after limited negotiation, Lang agreed to offer the amendment for House consideration,

according to the Society analyst. With ISMS and IHA working together to craft the legislation, the bill's chances for passage improved. However, despite the combined efforts of the two organizations, the bill's future is uncertain, because it is strongly opposed by business and insurance interests, the analyst said.

Those groups oppose most of the bill's provisions, including the standardization of the appeals process and the prohibition of contingency reviews. Business and insurance groups also believe that the liability and licensure requirements as spelled out in ISMS House of Delegates policy and the amendment are unnecessary, the analyst noted.

In addition, partisan and political bickering caused a stalemate in the Illinois House, the ISMS analyst said. At press time, more than 600 pieces of legislation, including H.B. 4050, remained on the House calendar to be considered before the deadline for bills to emerge from their house of origin, he said.

"Regulating UR entities remains a priority, and we won't accept a purely cosmetic measure that would foreclose further legislative discussion," the ISMS analyst concluded. "It will take time, but we want to work with all parties to ensure that physicians get regulatory relief from UR burdens and that patients continue to receive optimum care." ■

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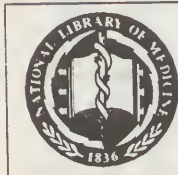
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The Blues to implement RBRVS payment schedule

REIMBURSEMENT: Physicians treating patients enrolled in two of the company's managed care products could see different rates. By Anna Chapman

[CHICAGO] Effective Aug. 1, Blue Cross and Blue Shield of Illinois is switching to an RBRVS-based payment system for its Managed Care Network Preferred and PPO Plus plans, according to Arnold Widen, MD, Blues' medical director. About 18,000 physicians will be affected by the new payment structure, he said. "We feel this is a much more fair and appropriate methodology for compensating physicians," Dr. Widen said. "Over the years, we feel that there has been excessive value placed on certain procedural services performed by physicians, as compared to the

cognitive or decision-making processes. This problem was appropriately addressed by the resource-based relative value system, which created new relative values for the services that physicians [perform]."

The new Blues payment system is "very similar to Medicare RBRVS," Dr. Widen said, explaining that it modifies the insurer's existing Schedule of Maximal Allowances for the two managed care plans. Average physician payments under the system will be twice those allowed under Medicare.

To implement the system, the Blues will use Medicare's established relative value units for physician services, he noted. RVUs reflect the resources necessary to perform services, including the time and intensity
(Continued on page 15)



Dr. Schneider

INSIDE

Madison County doctors speak to the community



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Ron Ackerman

AS ISMS PRESIDENT Alan M. Roman, MD, looks on, Gov. Jim Edgar announces that many groups, including ISMS, support his revised Medicaid reform package. The press conference took place June 7 in Springfield.

AMA prompts federal Patient Protection Act

LEGISLATION: A new bill in Congress seeks safeguards for patients who are selecting insurance coverage. By Kathleen Furore

[WASHINGTON] On May 23, the AMA announced the introduction of a new federal bill calling for insurance industry reforms that ensure freedom of choice for patients and fairness for physicians. If passed, the Patient Protection Act would help guarantee that treatment decisions are made by patients and their physicians – not by insurance companies, the AMA said. The legislation is already facing heavy opposition from the nation's "big five" insurers – Aetna, Cigna, MetLife, Prudential and Travelers – according to AMA communiques about the proposal. "Patients should no longer be subject to the 'health insurance lottery,'" said Lonnie Bristow, MD, chairman of the AMA Board of Trustees. "They should never be surprised to discover that their insurance doesn't cover their health care needs, that their regular doctor

can no longer treat them or that they won't be allowed access to the specialty care they need. We believe the Patient Protection Act guarantees basic patient rights and allows physicians to fulfill the responsibilities entrusted to them by their patients."

Introduced as H.R. 4527, the Patient Protection Act addresses four major areas: patient freedom of choice, disclosure of restrictive insurance policies, physician selection criteria and utilization review safeguards.

To ensure freedom of choice, the bill requires insurance companies to offer patients a choice of coverage. Their first two options would be an HMO or PPO, or a traditional insurance plan with copays and deductibles. Or patients could select a benefit payment schedule, which calls for the plan to pay a set dollar amount for ser-

(Continued on page 10)

Legislator applauds call for exam guidelines

STANDARDIZATION: Variations in women's medical examinations cause concern. By Anna Chapman

[SPRINGFIELD] State Sen. Judy Baar Topinka (R-North Riverside) recently praised ISMS and the Chicago Medical Society for actively seeking the development of basic guidelines for comprehensive medical examinations of asymptomatic women. Topinka, who serves as chairman of the Senate Public Health and Welfare Committee, said she has received complaints from constituents and she has read press reports that some women believe their health care concerns are not taken as seriously as men's concerns. "Some consensus needs to be arrived at on the tests and procedures that would be basic to all women's exams," she said.

"I've read numerous articles that provide statistics noting that women's health care complaints are sometimes passed off as neuroses," Topinka added. "Medicine is not an exact science, and each physician wants – and rightly deserves – to treat each of his or her patients as an individual, applying procedures they deem appropriate in each case. They

need to retain that freedom; there is no question about that."

Topinka stressed that physicians should not be locked into specifics and that she is not seeking legislation mandating set exam procedures. Legislative measures requiring physicians to follow inflexible guidelines could expose them to potential liability, she explained. "That concerns me, because I don't want this to turn into another lawyers' playground."

New guidelines are necessary to make sure physicians are "all on the same wavelength," said M. LeRoy Sprang, MD, an Evanston Ob/Gyn and ISMS secretary-treasurer. He cited disagreements between medical specialty organizations and the federal government about such issues as the appropriate age women should receive baseline mammograms as part of the reason standardized guidelines are needed.

"By having a set pattern, we can overcome
(Continued on page 10)

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Dr. Bristow (left) and Dr. Oltman (far right) show kindergarten students how to wear bicycle helmets.

County auxiliary promotes bike safety

HEAD INJURIES: Effingham kindergartners receive bicycle helmets and safety tips from local doctors. By Anna Chapman

[EFFINGHAM] During a May 19 bicycle safety presentation to kindergarten students in Effingham, two local physicians dropped one egg safely into a tub of sand and splattered another onto a concrete block to show how a bike helmet protects a child's head when a youngster hits the pavement. After the presentation by pediatrician Paul Oltman, MD, and family physician David Bristow, MD, all 324 children received a free bicycle helmet compliments of the Effingham County Medical Society Auxiliary.

"The distribution of 300 helmets creates a good ripple effect," said Dr. Bristow, who supports the adoption of a community ordinance requiring children to wear helmets when cycling. He noted that the children were positive and excited about receiving the helmets. "The message we gave the kids is that wearing a helmet is cool."

The auxiliary established the helmet giveaway after several children in the community died of head injuries sustained in bicycle accidents, said Carol Gapsis, auxiliary president.

"We're a rural community, and kids ride bicycles a great deal," Gapsis said. "We looked at the statistics nationwide and found that children had to fall a distance of only two feet to suffer brain injury. We also found that 75 percent of bicycle [accident] deaths are due to head injuries and helmets can reduce head injuries by 85 percent."

To start the program, the doctors rode into the school on bicycles. Dr. Oltman wore a helmet, and Dr. Bristow had his head bandaged and streaked with fake blood. "I am not cool," Dr. Bristow told the children. The physicians explained that some "uncool" kids might deride them for wearing a helmet, but they stressed to the students that such comments should not alter their decision to wear one. Drs. Bristow and Oltman then showed the children how to wear a helmet properly and performed the egg demonstration. "It was a very vivid demonstration. The kids were shocked," Dr. Bristow said.

"The children were so impressionable," Gapsis said. "They wanted to

wear their helmets out on the playground and on the school bus."

Several parents also attended the program, Gapsis said, adding that one parent remarked on the program's timeliness, since a neighbor had recently fallen and sustained a head injury.

To raise money to purchase the helmets at cost from Wal-Mart, the auxiliary held fund-raisers and collected donations from physicians and local businesses, Gapsis said. The auxiliary plans to continue the program annually and has applied for several grants, including a \$4,000 grant for bicycle helmet programs from the American Academy of Pediatrics, she added.

"I do a lot of bicycling, and I always wear a helmet," said Dr. Oltman, adding that he was encouraged to see children riding their bicycles and wearing their new helmets after the program. ■

Photo courtesy of the Effingham County Medical Society Auxiliary

Measles outbreak hits religious community

[ELSAH] The Illinois Department of Public Health recently confirmed 47 cases of measles in a community of Christian Scientists in Elsay. As part of their religious beliefs, Christian Scientists do not accept medical care, including immunizations.

The outbreak spread from Illinois to Missouri when 140 students at a Christian Scientist school in St. Louis were infected by a 14-year-old classmate who lives in Elsay and attends the school, said Therese Macias, administrator for the Jersey County Health Department. According to press reports, the outbreak is the largest in the United States this year. No deaths have been reported.

Among the 47 Illinois cases were 23 students and one staff member at Principia College in Elsay. A sibling of the 14-year-old attends the college, Macias said.

The Jersey County Health Department worked closely with Principia College to

contain the disease, Macias explained. The college restricted access to the campus; people entering or leaving the premises had to show proof that they had been vaccinated or that they had the disease in the past. "We did not demand quarantine; it was a voluntary closure," Macias said.

The department then began a large-scale vaccination campaign for college students and area residents. By May 19, when the department stopped offering vaccinations, 451 people had been immunized. "This is amazing in a religious community," Macias said. "They worked very well with us, and it really helped decrease the effect of the outbreak."

After the immunization push, only a few of the 319 resident college students remained unvaccinated, Macias said. Those students were isolated in cabins in a nearby wooded area when the college reopened June 1 for graduation. Outbreaks are not considered to be completed until 21 days after the last rash is reported, she added. ■

Cardiologists move from Loyola to Rush

[CHICAGO] Some cardiologists from Maywood's Loyola University Medical Center have moved to Rush-Presbyterian-St. Luke's Medical Center in Chicago. According to a story in *Crain's Chicago Business*, a 21-member team – including nationally renowned researcher Maria Rosa Costanzo, MD – will take its staff and research grants when it moves to Rush's Heart Institute in July.

"Treatment of heart failure is a growing area. And clearly, heart transplantation is an important aspect of that," said Joseph Parrillo, MD, director of cardiology at Rush and medical director of the Rush Heart Institute. "We were interested in recruiting people who had academic, research and patient care interests. And we feel very fortunate that this very, very impressive group from Loyola was interested in moving here."

Dr. Parrillo said the team's arrival will help Rush "build an academic section of cardiology considered the finest in the Chicago area and hopefully one of the best nationally."

A Loyola spokesperson, however, called news reports of the doctors' departure "overblown and inaccurate. Two or three cardiologists are leaving, and we're picking up others from other institutions," the spokesperson said, noting Loyola's leadership role in heart and lung transplants and its retention of 46 cardiologists, including many cardiac surgeons. "There's always turnover. And it's not the entire transplant team [that's leaving]."

According to Dr. Parrillo, four cardiologists, an immunologist, nursing personnel, a PhD researcher and research/technical staffers are moving to Rush.

Although this kind of situation occurs infrequently, it represents a growing trend in the competitive medical marketplace, according to James Unland, president of the Health Capital Group, a Chicago-based firm that provides consulting and management services to medical practices and hospitals nationwide. "It is rare, but certainly becoming more common – especially in the area of primary care," Unland said. "What struck me about this was the [reported] scale of the move. Moves of entire multidisciplinary teams are rare." Unland also noted it is unusual for specialists to be involved. "Primary care physicians are a scarce resource, but other [specialists] are in relative oversupply." ■

PHYSICIAN FACTS

HMO enrollment in Illinois*

1984

576,000

1988

1.75 MILLION

1994

1.88 MILLION

*Does not include HMOs that allow patients to leave network. All figures as of Jan 1.
Source: Illinois Association of Health Maintenance Organizations

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Marketplace feasibility study under way

As managed care evolves, the Society examines physicians' needs. By Anna Chapman

A study has begun that will help determine how ISMS can best serve Illinois physicians in the managed care marketplace. In the first phase of the study — scheduled for completion in September — data is being collected through interviews with ISMS board members, key market players and possibly large Illinois employers and major provider organizations. Through the study, ISMS will learn about the approaches being developed by providers and payers to respond to the need for cost-effective care. A health care consulting firm and a market research firm are conducting the study.

"The good news is that the better options for physicians and patients are down the road in managed care evolution," said Carol Emmott, PhD, director of the feasibility study. "That's one of the key reasons the Society is wise to look at these options and see how it can help advance the cause. If you can develop the kind of organizational structure to move beyond primitive managed care, there really are far better options for physicians."

The consultants will analyze the data and evaluate potential ISMS services related to various managed care entities, said John Ray, another consultant on the project.

The good news is that the better options for physicians and patients are down the road in managed care evolution.

The consultants will analyze the data and evaluate potential ISMS services related to various managed care entities, said John Ray, another consultant on the project.

THE CHANGES PHYSICIANS may make in their practices will be based on a wide variety of new managed care opportunities offering significant benefits to physicians and patients, said Ray, who is president of the Clearwater Group in California. The early stages of managed care involved decreasing fees for services and increased emphasis on external utilization control. "The reaction to that by physicians has been universally negative. Clinical care gets taken out of the physician's hand, and the economics are a downhill spiral," he said.

In more advanced managed care markets, financial control is shifting from third-party payers to physicians, which enables doctors to reclaim control of patients' clinical care, Ray explained. "That dynamic is the kind of thing we can help ISMS examine."

Emmott, president and chief executive officer of Health Direction Inc. in California, has conducted similar feasibility studies for hospital associations. The influence of hospitals over health care dynamics is also shifting, she noted. "They're looking at how they can keep a place at the table at a time when physicians are at center stage."

"For the Society, I see potentially exciting new program development and new kinds of roles for ISMS members," she continued. "Interestingly, hospitals may well see the reverse of that."

Also providing input into the study will be experts ranging from physicians knowledgeable in clinical medicine and managed care system operations to attor-

neys grounded in antitrust issues, Emmott noted. The consulting team will work with ISMS legal counsel to gain perspective on Illinois' health care climate.

"This team has direct ground experience with developing and operating physician organizations," Ray said. "We are here to serve as a resource, maybe as a catalyst."

Blue Cross Blue Shield



REPORT

FOR Illinois Physicians

RESOURCE BASED RELATIVE VALUE SCALE (RBRVS)

Blue Cross Blue Shield of Illinois (BCBSI) will initiate an RBRVS based physician payment methodology on **August 1, 1994** for physicians who participate in two of BCBSI's managed care networks, Managed Care Network Preferred (MCNP), which is a "point-of-service" product, and PPO Plus. These products currently comprise a small percentage of BCBSI's total business. The new physician payments will essentially be a modification of the Schedule of Maximal Allowances (SMA) presently in use for these two products. Usual and Customary (U & C) payments, still used in traditional health insurance lines, will not be affected.

This new methodology for payment of physicians was developed by physicians at Harvard University Medical School in 1988. This new payment system was based on an analysis of the relative value of physicians' services, taking into account the amount of professional resources that were required to perform specific services by physicians. The new system was called Resource Based Relative Value Scale (RBRVS), and was designed to provide an objective and more equitable basis for physician payments, than did the charge-based approach used previously. In general, RBRVS resulted in relatively more weight and payment being allowed for cognitive services, and relatively less weight and payment being allowed for procedural services. The RBRVS methodology has 3 main components:

1. **Relative Value Units (RVU's)** - These are weights that reflect the resources or input needed to perform specific services. The RVU's are based on three factors:
 - **Work** - The physician resources required to provide the service, including time and intensity of effort.
 - **Overhead or Practice Expense** - Costs such as rent, staff salaries, equipment and supplies, etc.
 - **Liability or Malpractice Insurance Expenses**
2. **Geographic Practice Cost Indices (GPCI's)** - Cost factors that reflect different costs of resources in different areas (urban vs. rural, etc.). In each location, a separate GPCI is applied to the same 3 factors (work, overhead, and liability) that comprise the RVU.
3. **Conversion Factor** - This is the number that converts the relative weights created by the RVU's and the GPCI's for each of the approximately 7,000 procedure codes into payment dollars. The weights are multiplied by the conversion factor to obtain the payment.

For each procedure code, the following formula determines the actual payment:

$$(\text{Work RVU} \times \text{Work GPCI}) + (\text{Overhead RVU} \times \text{Overhead GPCI}) + (\text{Liability RVU} \times \text{Liability GPCI}) \times \text{Conversion Factor} = \text{Payment Allowed}$$

Medicare was mandated by the U.S. Congress to implement RBRVS-based physician payments on January 1, 1992. Medicare has been following a "phase-in" of RBRVS over several years. BCBSI will use the same RVU's and GPCI's as does Medicare, but the conversion factors will be significantly greater, resulting in substantially higher payments than those of Medicare.

BCBSI wants to assure physicians that BCBSI truly believes RBRVS-based physicians' payments to be a more fair and appropriate physician payment methodology than were previous approaches, and that, therefore, RBRVS payments are in the long-term best interests of all physicians. Finally, in this era of health care reform, this new approach to physician payments will be another demonstration to the public of how the largest health insurer in the State of Illinois, BCBSI, can work cooperatively with physicians to institute desirable reforms without unneeded and unwanted governmental mandates.

Madison County doctors speak to the community

REFORM: Physicians establish a speakers bureau to educate the public about changes in health care.

By Anna Chapman

[ALTON] Madison County doctors have launched a grass-roots effort to inform area residents about the changes they may face under health system reform. The physicians formed a speakers bureau and are talking about health care reform at town meetings, on radio programs, to church groups and to anyone else who will listen, said Robert Hamilton, MD, ISMS Sixth District trustee and

a participant in the speakers bureau.

"Some of us feel that a lot of grass-roots education needs to be done," Dr. Hamilton said. "The people we're speaking to are very interested in the doctors' message. They really want to hear it. They also appreciate that we took the time to talk to them. It means a lot when a physician cares enough to do this."

The idea for the speakers bureau was

sparked by a resolution adopted by the ISMS House of Delegates in 1993 to establish a grass-roots education campaign regarding health care reform, Dr. Hamilton said. The program was developed after several Madison County physicians participated in ISMS' speaker training program held throughout the state in December 1993 and January 1994.

Since the beginning of this year, the 15 physician members of the speakers bureau have held a town meeting at Alton Memorial Hospital and addressed various groups and organizations, including a local chapter of the American Association of Retired Persons, a gathering of retired federal employees and the health care committee of the Southwestern Illinois Industrial Association.

A few physicians, including Tim Kisabeth, MD, president-elect of the Madison County Medical Society, have also fielded questions from listeners on a local radio station. Typically, the radio callers ask general questions about reform, economics and lifestyle changes, Dr. Kisabeth said.

"We've had warm receptions from people who want information and want to know how they can be involved," Dr. Kisabeth said. "We are making ourselves available to those who are willing to listen and encouraging them to participate in the

process, not just let it happen to them."

Several speaking engagements have centered on the Clinton plan, Dr. Hamilton said. Other topics speakers have addressed include the importance of maintaining physician-patient relationships and cost containment. Physicians have also discussed how various reform plans will affect patients, Dr. Hamilton noted.

"We try to cover the whole spectrum," he said. "We've been pretty frank. I don't hesitate to say that some of these [health care reform] programs will treat physicians and patients like livestock — that we won't have much choice."

During his presentations, Bruce Reid, MD, an Alton orthopedic surgeon and a native of Canada, explains the problems of the Canadian single-payer system. He said he moved to the United States in part because of his frustration with the Canadian system, which is known as Medicare. "I've seen how Medicare was thrust upon people. Canada has failed miserably."

Dr. Reid said he gets excited about helping people understand the issues and take action. "I want to get them agitated. We have to spell out what the programs mean and let them make up their own minds. People aren't stupid, and they get offended when someone else is deciding what their minimum benefits will be."

Dr. Reid said he also stresses the importance of getting involved in the legislative process and encourages attendees at his programs to find out who their legislators are and write to them. "It doesn't take much. Thirty to 40 letters can make an impact."

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

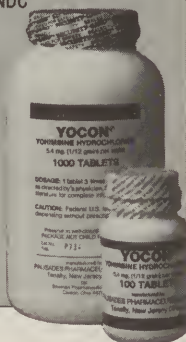
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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Groups protest tobacco advertising aimed at children

[CHICAGO] To commemorate World No Tobacco Day, the American Lung Association of Metropolitan Chicago and INFACT, a Boston-based consumer group, held a brief memorial service for tobacco victims on May 31 under a Marlboro billboard in Chicago. During the service, participants passed out brochures and carried signs saying, "Honk if you are opposed to tobacco slaughter." The event marked the start

of a Chicago campaign to "send Joe Camel packing," said Michael Brennan, an INFACT spokesperson.

"Every year, 3 million people in the world die from tobacco use," Brennan said. "That would wipe out the whole city of Chicago in one year."

Throughout the summer, INFACT members will encourage Chicago retail merchants to remove Camel cigarette displays from their stores. The goal of the

campaign is to prevent tobacco companies from marketing their products to children, Brennan said.

Since 90 percent of smokers begin using tobacco as teen-agers, the American Lung Association and INFACT are trying to eliminate tobacco industry efforts to attract young smokers, such as the Joe Camel campaign, Brennan explained. Before the Joe Camel campaign was launched, less than 1 percent of smokers under 18 smoked Camels. After the campaign ran for two years, the figure jumped to 33 percent, he said.

"The time has come for a frontal assault against the leading purveyors of death and disease embodied by the

tobacco industry," said Alfred Munzer, MD, president of the American Lung Association. "INFACT's record of arousing the public's conscience to other issues places it in an ideal position to lead a grass-roots battle."

World No Tobacco Day is an annual event sponsored by the World Health Organization. This year's theme was "The Media and Tobacco: Getting the Health Message Across." It emphasized the need for collaboration between public health workers and media representatives, especially in developing countries where tobacco use is increasing, according to the U.S. Centers for Disease Control and Prevention. ■

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Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

A serious look at summer fun

Remember the old days when we and our patients could indulge ourselves during the summer without worrying about the related health risks? Now we know better. Take sun exposure, for example. Several medical groups recently issued guidelines for protection from skin cancer.

Children are especially at risk. They spend three times as much time in the sun as adults, according to the American Academy of Pediatrics. At least one out of every six children will grow up to develop skin cancer, and before the age of 20, people are exposed to 80 percent of the dangerous ultraviolet radiation they will face during their lifetime, noted the AMA. A study published in the May issue of the *Journal of the American Academy of Dermatology* said there are between 900,000 and 1.2 million new cases of non-melanoma skin cancer per year in the United States. And in 1993, melanoma was diagnosed in about 32,000 people. Other health problems related to ultraviolet exposure include cataracts and weakened immune responses.

The National Weather Service plans to supply several cities around the country with a daily ultraviolet index to warn people when high amounts of ultraviolet light are present. But clearly, routine caution and prevention are critical.

During the summer, children are also riding bicycles more, often without any

protection. Thanks to the efforts of the Effingham County Medical Society Auxiliary, 324 children recently received free bicycle helmets. To help dispel the idea that wearing a helmet isn't "cool," physicians presented a short program, including a demonstration about what happens with and without a helmet when a child falls from a bike. The auxiliary and the doctors involved should be commended on their efforts to prevent children's injuries.

Even patients who are careful about their diets and fat intake most of the year become a little careless in the summer. At many gatherings, the prevalence of cigarettes is rivaled only by that of ice cream cones. A recent study sponsored by several medical groups and reported in the *New York Times* said health care costs would decrease by as much as \$17 billion per year if Americans reduced their daily intake of saturated fat by just 8 grams – about the amount of fat in a half-cup of ice cream. That decrease would reduce coronary heart disease by 36 percent, according to the American Heart Association.

Counseling patients about diet, safety and ultraviolet exposure may not exactly be a day at the beach, but it can make a difference. However, while you're at it, don't forget to prescribe *some* summer-time fun.

PRESIDENT'S LETTER

Children are the message of today to the tomorrow we will not see

Alan M. Roman, MD



Parenting is a full-time job, as is doctoring, involving high standards that demand dedication.

Let me set the stage: Flossmoor Little League, an early Saturday evening in late May with my pager showing mercy. A schoolyard diamond with an infield of golden sand mixed with chalk dust and crabgrass flourishing everywhere else. Cubs vs. the Reds. Top of the fourth, one out, a man on first. My 7-year-old, Justin, at the plate, wearing his red, blue and white Cubs uniform with his white and black baseball shoes and his favorite laces. You probably know what's coming – a bases-clearing home run that emptied the battered aluminum bench as teammates offered roars of approval, rounds of high fives and backslapping encouragement. My daughter, Lindsay, playing on a swing set behind the home plate backstop, barely noticed. For Justin, the moment, I'm sure, was indelibly etched in brilliant Kodachrome imagery inside his head as another first he will treasure forever.

Call it pride or call it pleasure, for me it was a really important game. It was a fusion between my dreams and desires and Justin's capabilities and potential. I know there is more than a love of words at work here, more than a truth-piercing reacquaintance with my own lost childhood. Granted it was Saturday evening, 79 degrees, a holiday weekend, and hearts were a little lighter. But at this one moment in time, life felt unexpectedly and extraordinarily good.

The greatest single determinant of what you will be or do with your abilities is your perception of who you are. It is thought that by the time you've reached the age of two, 50 percent of what you ever believe about yourself is formed and 70 percent by age seven. No wonder then that the first base of successful living is self-acceptance.

Self-esteem is central to success in any endeavor. It's self-concept that is at the core of one's personality. It affects every aspect of human behavior, including our ability to learn, the capacity to grow and change and our choice of friends and careers. The early years then are important for cultivating a sense of self, and the self-

esteem a child relies on later in life is a product of what he or she has felt along the way.

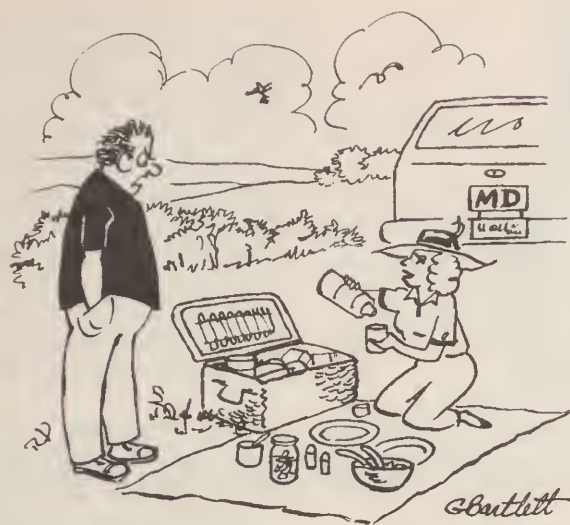
Parenting is a full-time job, as is doctoring, involving high standards that demand dedication, availability and compulsivity. Justin relies on me not only for love and affection, but also for the value judgment he will finally find most important, and that is the estimate he will place on himself. In return, parents receive from their children love, memories, comfort and pride. "Not only is Dad my best friend, but he's also my dad," Justin said nonchalantly this past week. I'll always be grateful to him for the pleasure of his most innocent remark.

What it is we really want is not for our kids to be just like us. But when they are most themselves and we are most ourselves, and our minds meet, there is a special connection. Childhood was too short the first time around, but with the practice I've had, I'm becoming even better at it now.

The papers are full of stories of parents who strike their children or tell them day after day that they are worthless or bad. Simply by having produced children, parents have the power to make them feel good or bad about themselves, which is the greatest power in the world at their earliest time of influence. I have found that my life is now simply no longer my own, and by being generous with praise, I can make another rich in self-worth. Nothing speaks more loudly to a child than a parent's quiet, good example.

So this is how it goes. It begins as T-ball, blossoms into Little League, and maybe with a lot of work and some luck, it ends with self-awareness. Certainly it is not an easy world to live in. It is not an easy world to understand oneself in. Nor is it an easy world to raise children in. Too soon it will be time to pass the baton, and as in any relay race, the hope is that there will be little loss of momentum.

(Continued on page 15)



"I can't relax. The crickets sound too much like my beeper."

GUEST EDITORIAL

Bike helmets prevent injuries

By Mark Rosenberg, MD

Now that warmer weather has finally arrived, more children are out on the streets riding bicycles. But too often during these warm months, pediatricians are called to emergency rooms to care for children who have fallen off their bicycles and sustained head injuries.

Each year, 400,000 children nationwide visit emergency rooms for treatment of bicycle-related injuries; one-third of those are head injuries. Injuries sustained in a bicycle crash can be devastating and lead to death. In 1991, for example, 27 deaths in Illinois were caused by bicycle accidents, most of which involved a motor vehicle.

The lifetime medical payments for individuals seriously injured in bicycle accidents in 1991 will run nearly \$200 million. For a child who sustains a severe head injury and is permanently disabled, rehabilitation costs can exceed \$1 million, not to mention the devastation to the child and his or her family. Frequently, the costs associated with such lifetime care are borne by the state, because individual insurance coverage can be exhausted by such intensive and long-term care.

Bicycle helmets are effective in preventing injuries, but only 10 percent of children wear them. We know that 90 percent of serious head injuries can be prevented if children wear approved bicycle helmets.

Education campaigns promoting helmet use have not been effective in generating parental awareness and offsetting the strong influence of peer pressure, which prevents young children from wearing helmets. Although there is some evidence showing that children who begin wearing helmets at an early age continue to use them, many children bend under peer pressure and stop wearing helmets.

Pediatricians and family physicians have traditionally included safety issues in their guidance to patients and their

families. But just as education campaigns and counseling were not very effective in convincing people to wear seat belts, physicians are having only limited success using those techniques to convince children to wear bicycle helmets. It's the combination of legislation mandating helmet use and education campaigns that has been shown to be the most effective approach for assuring compliance.

During the current legislative session, a bill requiring children under 16 to wear an approved helmet when riding a bicycle was introduced in the Illinois House of Representatives by Rep. Jeffrey Schoenberg (D-Wilmette). The bill also requires children under 16 years to wear helmets when they are passengers on bikes. The bill allows for the waiver of fines collected for noncompliance if evidence is produced showing that the child purchased an approved helmet. In addition, any fines collected would be deposited in a fund to purchase helmets for children in low-income families.

If the bill passes, Illinois will become the eighth state to pass such legislation. The laws are working. In New Jersey, a bicycle helmet requirement increased the percentage of children wearing helmets to about 60 percent, up from 5 percent before the mandate. In addition, the requirement lowered the number of deaths caused by bicycle injuries from 10 to two.

The adoption of bicycle helmet legislation will result in a steady increase in compliance analogous to the increased use of seat belts seen in the last decade after mandatory seat belt laws were passed.

Help children have fun and avoid preventable injury. Encourage your young patients to wear helmets.

Dr. Rosenberg is chairman of the government affairs committee of the Illinois Chapter of the American Academy of Pediatrics.

Pediatricians and family physicians have traditionally included safety issues in their guidance to patients and their families.

GUEST EDITORIAL

Don't divert research funds

By Jerry D. Gardner, MD

This article originally appeared in the April 29 edition of the St. Louis Post-Dispatch. It is reprinted with the author's permission.

Basketball, blue jeans and medical science are areas in which America is clearly the world leader.

At the last summer Olympics, opponents of our Dream Team looked forward to the end of the game to get autographs from and have their pictures taken with our players. American blue jeans are so popular that they are a form of currency in some countries. Our medical science represents the unquestioned standard of excellence for the rest of the world, and this has occurred through laboratory and clinical research in specialty medicine, not by promoting primary care.

There is a growing popular assumption that if more doctors operate on the "front lines," providing primary care rather than becoming high-priced specialists who grow rich doing procedures – or researchers who waste millions of dollars of taxpayers' money studying esoteric subjects – we'll all be a lot better off in terms of price, availability and quality of our health care.

The United States is currently a world leader in medicine because our basic science researchers and specialty practitioners have extended the boundaries of science and technique to provide our primary caregivers with increasingly effective clinical tools. If we change this dynamic, the next generation of primary care doctors – while there may be more of them – will be practicing yesterday's medicine, not tomorrow's.

Although this country has experienced a steady, significant increase in the number of primary care doctors over the past 10 years, health care reform proposes incentives and disincentives that would shift even more residents and practicing physicians into primary care.

Under the reform proposals, financial incentives would be offered to medical schools to establish programs that funnel medical students into primary care. In addition, the number of residency positions would be capped, with about 60 percent reserved for primary care.

The problem is that primary care doctors don't do research. They deliver high-quality medical care using diagnostic tools, procedures and drugs developed through the myriad specialty areas in medicine – the very areas that current proposals would significantly reduce.

For example, consider how drugs are developed. The drug development process is long. Many chemical compounds are developed and tested in the research laboratory. A few are then found suitable for testing in experimental animals, and of these compounds, a small fraction is eventually evaluated in humans.

At every step, people in industry and academic medicine, in laboratory research and clinical research, work together to test, adjust and retest new therapeutic compounds. And these studies virtually always involve specialists at academic health science centers, not primary care physicians. Quite simply, if we reduce the number of trained special-

ists who can do this work, we limit our ability to make new drugs available.

The funds necessary to shift more physicians into primary care will almost certainly be diverted away from research, thereby mortgaging the future of American health care. When the American public picks up a newspaper or turns on CNN to learn of a great medical breakthrough at St. Louis University Health Sciences Center or any other major medical institution, many do not realize that it is their money that has paid for the research that made this development possible.

More than 90 percent of all medical research is funded by government grants from the National Institutes of Health awarded to researchers in university medical settings. These funds will shrink as they are shifted toward paying for many of the new initiatives – including the residency incentive programs – and other elements of the health care program.

Thus, significantly less money will be available to do the things that have allowed this country to reach pre-eminence in the field of health care – in addition to a loss of the very infrastructure that allowed the advances. Currently, other countries send their physicians to the United States – for the high-quality medical training they receive. But if the proposed approach is enacted, we'll be sending our physicians abroad to learn to do things right.

In this leaner environment with redefined priorities, many are suggesting that the government support only research that is "application oriented," rather than simply being "good science" – the criterion that has historically been used when evaluating research proposals for NIH funding.

The breakthroughs that have contributed to this nation's pre-eminence in medical care have come from basic scientific research, not from targeted research projects "out to find a cure" for a specific disease, such as AIDS or arthritis. Investigators know that using the disease-oriented approach is counterproductive as a framework for funding and conducting research. Politics and tight budgets will not change the rules of scientific discovery. It is the study of basic biologic processes that ultimately brings us the incremental progress toward better health and quality of life for humans. For example, studies of a chicken virus seemed remote but led to the discovery of the cause of cancer.

Finally, in America when our families are seriously ill, we expect solutions to our problems – no matter how complex or severe. We have faith in – even demand – the availability of increasingly sophisticated technology, medicine and knowledge from our medical institutions. This will no longer be the case if we begin shifting our priorities unduly toward care, rather than maintaining an appropriate balance of care, basic research and development.

Dr. Gardner is associate chairman of the department of internal medicine at St. Louis University Health Sciences Center.

Delegates adopt credentialing policy

RESOLUTIONS: The ISMS House of Delegates considers HIV reporting and quotas. By Tamara Strom

The House adopted two policy statements regarding physician credentialing by managed care organizations. The first resolution, introduced by Vedantham Srinivasan, MD, a

ANNUAL MEETING WRAP-UP

DuPage County delegate, called on the Society to seek legislation or other means to stop annual physician credentialing by managed care insurance

carriers. The measure also directed ISMS to submit a resolution to the AMA House of Delegates asking the AMA to adopt similar policy.

Supporting testimony indicated that hospital medical staffs recredential physicians every two years and that this frequency should be sufficient for managed care plans.

The second credentialing-related resolution dealt with managed care pro-

grams that arbitrarily prevent qualified physicians from participating in their plans. The resolution, submitted by Sandra Olson, MD, chairman of the Cook County delegation, supported the "any willing provider" concept included in some reform legislation.

The House adopted a substitute resolution stating that managed care programs may not drop a physician from plan participation without due process. The sub-

stitute resolution also said that when physicians are denied participation in a managed care plan, the organization should state all the reasons the physician was not accepted or was dropped, as well as provide evidence showing how the doctors' practices failed to meet the plan's published participation requirements. In addition, the resolution directed ISMS to seek legal and legislative action, as appropriate, to prohibit managed care programs from denying participation by qualified physicians.

Named HIV reporting

Saying they want HIV to be treated the same as other sexually transmitted diseases, delegates adopted policy calling for HIV-positive individuals to be reported by name to the appropriate public health authorities. Introduced by delegates George Beranek, MD, and Rosemary McHugh, MD, the resolution directed ISMS to prompt legislation that mandates named HIV reporting to allow for notification of exposed sexual contacts. Notification would be confidential and limited to only those contacts. Current Illinois law requires HIV and AIDS reporting, but only individuals diagnosed with AIDS are reported by name.

During floor debate, several physicians expressed their frustration about treating HIV-positive patients and being unable to notify those patients' sexual partners. Most physicians who spoke on the issue said they believed that it is time to consider HIV a public health concern and that reporting HIV-positive individuals by name will help contain the spread of HIV.

Quotas in residency programs

Delegates also addressed the issue of quotas in residency programs. The original resolution, introduced by the Medical Student Section, called for ISMS to oppose any health care reform plan that restricts funding to residency programs based on a quota system.

In its report, the reference committee cited the Board's endorsement of a report from the Council on Education and Manpower, "ISMS Principles on the Training and Retention of Primary Care Physicians in Illinois." According to the report, ISMS does not believe that quotas will solve the state's primary care physician shortage. Therefore, ISMS' opposition to quotas should not be limited to quotas imposed by reform plans, the reference committee said. The House agreed and adopted an amended resolution that did not specifically refer to residency quotas established through reform.

Universal immunization availability

The House adopted a resolution directing ISMS to ask the Illinois Department of Public Health to provide free immunization materials to practicing physicians who treat children.

Supporters stressed that any effort to improve childhood vaccination rates is valuable. Although they acknowledged that children may currently receive free immunizations at public health clinics, many physicians said that those children may not receive appropriate well-child care from physicians. In addition, doctors said some counties do not have local health departments, which makes access to the vaccines difficult. They also said that the health departments' hours are often inconvenient for working parents and that physicians typically have office hours in the evenings and on weekends to accommodate those individuals. ■

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ISMIE Update

Don't forget
your
premium
payment

ISMIE adds free clinic policy option

COVERAGE: New benefit protects physicians who see patients at free medical clinics. By Kathleen Furore

[CHICAGO] To help expand its comprehensive roster of physician-oriented services, ISMIE has implemented a policy enhancement that allows doctors to treat patients at free clinics without worrying about the potential expenses of a malpractice suit. The new Free Medical Clinic Coverage program guarantees that the costs of any malpractice litigation arising from services delivered at a free clinic will be covered, according to Harold Jensen, MD, chairman of the ISMIE Board of Governors.

"Physicians who deliver care in free medical clinics are making an important contribution to their communities and to the medical profession," Dr. Jensen said. "Our new Free Medical Clinic Coverage option will facilitate that kind of involvement. For little or no cost, depending on the physician's circumstances, this insurance will pay legal expenses incurred in defending a suit filed as the

result of services administered to patients in free clinics."

According to the Medical Practice Act of 1987, physicians who provide "medical treatment, diagnoses or advice as a part of the services of an established free medical clinic providing care to

patients from taking legal action against clinic physicians.

"Physicians are immune from liability, but they are not immune from litigation and defense costs," he explained. "The new coverage ISMIE is offering ensures that those defense costs, which can be substantial, will be paid."

The Medical Practice Act defines a free medical clinic as an "organized community-based program providing, without charge, medical care to individuals unable to pay for their care." It stipulates that such care "shall not include the use of general anesthesia or require an overnight stay in a health care facility."

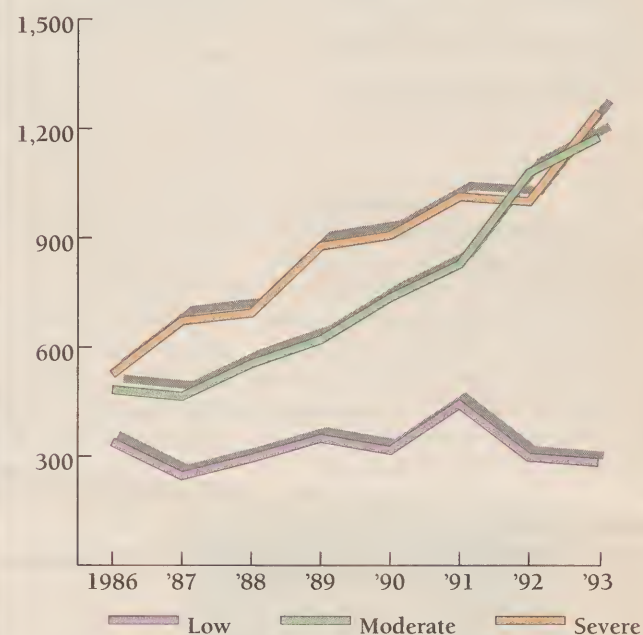
The Free Medical Clinic Coverage program is available to retired physicians, as well as to practicing physicians who are insured by carriers other than ISMIE, Dr. Jensen said. Active ISMIE policyholders already have such coverage under their

*Physicians who
deliver care in free
medical clinics are
making an important
contribution.*

medically indigent patients" and who are not paid for their services cannot be held liable for civil damages except in cases of "willful or wanton misconduct." But Dr. Jensen stressed that nothing in the act prevents

Severity of ISMIE claims

By number, severity and year reported, 1986-93



Source: Illinois State Medical Inter-Insurance Exchange

existing policies, he explained.

"This new program underscores ISMIE's commitment to serving physicians and to helping doctors give something back to the communities in which they practice," Dr. Jensen said. "We hope this coverage pro-

vides security by eliminating the threat of lawsuit-related costs for Illinois physicians who want to treat patients in free clinics."

For more information about this or other ISMIE programs, physicians may call (312) 782-2749 or (800) 782-4767. ■

MALPRACTICE ROUNDUP

Data reveal most frequent causes of malpractice claims

A recent study conducted by the Physician Insurers Association of America listed neurological and other birth-related injuries as the leading causes of malpractice claims against physicians. The study also revealed that cancer, fractures and spinal problems, and cardiac arrest and heart disease also accounted for a large number of malpractice claims. The results were based on more than 102,000 open and closed claims and suits reported by 22 of the association's 44 member companies as part of PIAA's Data Sharing Project. The most recent statistics were culled during a six-month study cycle ending June 30, 1993.

According to the PIAA report, the 10 specialties with the highest number of claims were the following:

- Ob/Gyn, with 15 percent of the claims;
- Internal medicine, with 14 percent;
- General surgery, with 12 percent;
- General/family practice, with 11 percent;
- Orthopedic surgery, with 11 percent;
- Radiology, with 6 percent;
- Anesthesiology, with 4 percent;

- Pediatrics, with 4 percent;
- Ophthalmological surgery, with 3 percent; and
- Neurosurgery, with 2 percent.

According to the study, general/family practice claims had the highest percentage of cases closed with payment, and pediatric claims had the highest average payment per closed case. Overall, the average indemnity per claim increased 10 percent since 1987. ■

Fear of transmitting HIV to third party not grounds for suit

According to a report in *Medical Malpractice Law & Strategy*, a hospital can't be sued because of a patient's fear of infecting a third party with HIV. In *Coleman vs. Oberman*, a Michigan appeals court ruled that a woman who contracted HIV from a blood transfusion she received at the University of Michigan Medical Center in 1984 could not sue the hospital based on her fears of infecting her husband. The couple alleged that the hospital was negligent in failing to notify them of her HIV status before 1988. The husband claimed he was afraid of contracting

AIDS, but he tested negative for HIV. The appeals court held that state law does not allow for damages to be awarded for emotional distress in the absence of injury. ■

Apology is not evidence of liability

The Supreme Court of Vermont ruled that apologizing for performing an "inadequate" procedure does not sufficiently establish malpractice liability, according to a case summary in the *Malpractice Reporter*.

In *Phinney vs. Vinson*, the plaintiff underwent a transurethral resection of the prostate. After experiencing recurring pain, the patient had follow-up surgery performed by another physician. The second physician allegedly told the first doctor that the original resection had been "inadequate." The physician who performed the first procedure later apologized to the patient for failing to perform an adequate resection.

In its finding for the first physician, the court stated that his apology was insufficient to establish an applicable standard of care or to show breach of that standard or causation. Summary judgment for the doctor was affirmed on appeal. ■

Protection act

(Continued from page 1)

vices and the patient and physician to determine how much the patient pays, the AMA said.

The measure also allows patients to add a point-of-service option for an extra annual premium. In addition, the AMA-supported bill states that patients are entitled to receive survey information about how other patients feel about the health plan, according to AMA background material.

*When you're dealing
with the health
insurance industry,
what you don't know
really can hurt you.*

The bill also requires insurance companies to disclose information about which services their plans cover and which are excluded. Similarly, the AMA measure mandates that insurers provide patients with easy-to-understand instructions regarding pre-authorization requirements. Patients would also receive information about any financial incentives for health professionals to withhold or limit services and any restrictions on referrals to medical spe-

cialists. In addition, insurers would be required to disclose the percentage of premium dollars spent on direct patient care services and patient satisfaction data, according to the AMA.

PHYSICIAN SAFEGUARDS are also included in the bill, the AMA said. For example, insurance companies would have to divulge their selection criteria for physician participation in health plans and could not terminate physician contracts without cause, according to the bill. Insurers would be required to specify all reasons for denying a physician's application or terminating a contract, and to provide due process for adverse actions. No physician could be removed from a plan for administering necessary patient care.

The proposal also establishes utilization review protections such as mandates that insurers identify reviewers. In addition, it calls for medical policies governing coverage and payment to be based on sound clinical and scientific data – not a company's bottom line. The bill also provides participating physicians with a formal mechanism for input into plan policies regarding credentialing, coverage, quality and UR, according to the AMA.

"The Patient Protection Act once and for all will expose insurance companies and managed care plans to the bright full light of patient and public scrutiny. Because when you're dealing with the health insurance industry, what you don't know really can hurt you," said Dr. Bristow. ■

Exam guidelines

(Continued from page 1)

some of the discrepancies and provide the best possible health care," Dr. Sprang continued. Physicians need to determine the baseline about what constitutes quality care, he added.

At the ISMS Annual Meeting in April, the House of Delegates adopted a CMS resolution asking the AMA to develop specific guidelines for women's health exams. Among the issues new guidelines should address is the appropriate frequency for Pap smears, mammograms and breast exams, said CMS President Sandra Olson, MD.

According to Dr. Olson, the AMA issued guidelines in the early 1980s for medical exams of healthy people, but CMS believes they are outdated and should focus more on women and the use of mammography. "When we looked into the issue, we decided it needed to be revisited at the national level," she said.

"As an umbrella organization, the AMA has input from numerous specialty societies," Dr. Sprang said, explaining that the AMA is the organization most likely to achieve guidelines consensus among physicians. "The federal government is looking at the issue only from the perspective of cost-effectiveness."

"Women worry about a number of things," Topinka explained. "They worry about breast cancer. That is one of the major killers of women in America." She said she believes that physicians should be required to perform breast

exams during physicals and that Pap smears should be mandatory for women of childbearing age. In addition, more attention should be paid to the dosage prescribed in birth control pills, she added. "Certainly physicians should ask whether women smoke."

Topinka said physicians should "tune up their ears" to what women are saying so that they can "hear the signs of alarm. It may be that physicians should be somewhat of a reporter, asking the who, what, when, where, why and how."

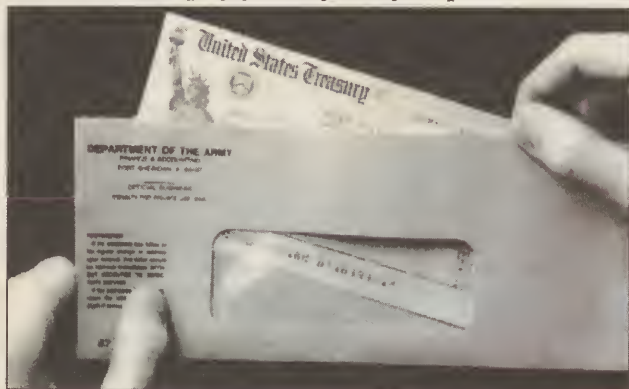
Women in the workplace now face the same kinds of stress that men have faced over the years, Topinka noted, adding that women also still assume most household responsibilities. Although the number of women suffering heart attacks is rising, most national studies have focused on men and excluded women because women's "hormonal structure poses too much of a variable," she said. "We have to start folding women into those studies, because we're doing the types of things that men traditionally have. As a result, even our estrogen is not going to protect us from heart attacks."

Topinka cited a study conducted in Seattle last year in which 57 actresses claiming identical family histories and health conditions visited different physicians in the area. "Some 'patients' were given as little as five minutes of the physician's time, others up to one hour. Charges ranged from \$24 to \$108. While time spent and fees charged are bound to vary, those seemed far too wide."

"Judy Baar Topinka is trying to serve the citizens of Illinois, and I think it's a great idea," Dr. Olson said. "But this is

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to the patient.*

not something that should be constrictive. She's looking for some way to standardize [exams] so that someone doesn't get shortchanged. And that's appropriate. On the other hand, there are always going to be individual variations in a physician's approach to the patient. She's trying to smooth out some of those wide variations and get some consensus on what should be done."

"I think women should be able to expect a predictable minimum number of issues covered when they go in to have a physical," Topinka said. "I am very pleased that the Chicago Medical Society and the Illinois State Medical Society agree that forming basic guidelines for women's health exams is important. I thank them for their efforts in urging the American Medical Association to revisit this question and give physicians, not only in Illinois but nationwide, a good, uniform guideline on the procedures to apply in women's health." ■

LEGISLATIVE INVOLVEMENT

The politics of medicine

Physicians participate in grass-roots efforts to shape health care legislation.

BY KATHLEEN FURORE

Until last fall, voting regularly was as close as Norman Johnson, MD, had ever come to being politically active. But as his dissatisfaction with the health care debate grew, so, too, did his desire to raise his voice in the reform dialogue.

"I was frustrated with the system and had the feeling I wasn't capable of doing anything to change it," said Dr. Johnson, a Pekin internist. "And then it occurred to me that health care reform is a political issue and that I'd have to get involved with the political process to have an impact."

Fueled by his frustration, Dr. Johnson kicked off his personal campaign to effect change. In October, he began working with Ray LaHood – the Republican candidate for the 18th Congressional District seat now held by House Minority Leader Robert Michel of Peoria, who is retiring after this term – and organized a series of town meetings in physicians' homes. "For the past 19 elections, all Bob Michel had to do was run a few television ads, and everyone would vote for him. But I knew this election was going to be a real horse race," said Dr. Johnson, explaining why he chose the 18th District race as his political cause. The race pits LaHood, Michel's former chief of staff, against Democratic challenger Doug Stephens, a trial lawyer.

"I didn't think we needed another trial lawyer going to Congress. And I wanted to make sure Ray LaHood understood his constituents' problems and concerns," Dr. Johnson said. "We started the town meetings,

which were fundraisers, in early February, and their popularity just grew. There were about 10 physicians at the first meeting, 20 at the second, 40 at the third and 60 at the last one in early March. The physicians were really energized."

Dr. Johnson said the meetings proved to be educational not

only for LaHood but for physicians as well. "What he got from us was the depth of our feelings – our anger, hostility and terrible frustration about being held out of the [health care reform] debate. He learned the Society's position on issues like antitrust and tort reform. And he conveyed to us the reasons we can't just go in and wipe out malpractice. He explained the political realities."

Building on the energy generated at the town meetings, Dr. Johnson rallied physicians to help plan a major fund-raiser for LaHood. The May 23 event, held at the Pere Marquette Hotel in Peoria, featured former defense secretary Dick Cheney as the keynote speaker and commanded ticket prices of \$500 and \$1,000 per couple. Calling the fund-raiser a "big, big success," Dr. Johnson said nearly 600 people attended the event, which garnered about \$150,000 for LaHood's campaign. Dr. Johnson said he hopes to help organize another fund-raiser later this year.

Local physicians have been instrumental in helping LaHood understand the medical community's concerns, said MaryAlice Erickson, his campaign manager. "Dr. Johnson has been terrific. He has really been the spark plug for all the doctors in the area. I know how busy doctors are, yet they've taken the time to meet with us several times. The physicians' input is very important and will be helpful to Ray when he has to make difficult decisions on health care reform." Erickson also noted the efforts of other physicians, including town meeting hosts Doug Harrington, MD, in Pekin; Lizbeth Taylor, MD, and Michael Taylor, MD, in Morton; and Joe Banno, MD, in Dunlap.

DR. JOHNSON'S POLITICAL participation is not limited to Pekin and Peoria. In March, he traveled with an ISMS delegation to Washington, where he spoke with Bob Michel's chief of staff about reform issues of importance to physicians. "I wanted to get him [Michel] to sign on to an antitrust bill and get him to support tort



Dr. Johnson

Photos by Linda K. Henson



LaHood

LEGISLATIVE INVOLVEMENT



Dr. Kobler (left) and Rotello

James P. Rogers

reform," Dr. Johnson said. "I related personal stories about physicians' experiences with antitrust and tort reform to show how [the absence of related legislation] can hurt medical care and delivery."

Like Dr. Johnson, physicians throughout Illinois are becoming more involved in

the political process. For example, William Kobler, MD, a Rockford family physician, traveled to Springfield in early May to observe the state legislature in action. He talked to ISMS legislative aides, visited the House while it was in session, attended a House committee hearing and spoke with legislators, including Rep. Michael Rotello (D-Rockford). Dr. Kobler finished the day at a medical education reception.

"We've had legislators involved in seeing what we do, so I thought it would be good to see what they do," said Dr. Kobler, adding that he has been "moderately active in meeting with local representatives in Rockford." He also went to Springfield in the mid-'80s

to lobby for malpractice liability reform.

"Although I don't think the session I saw in the House was totally typical — things were in such an uproar, and they were into this blocking mode — it was definitely worthwhile," Dr. Kobler said. "In listening to the discussions on the House floor, it became pretty obvious how uninformed many legislators are about some real basic facts about health care."

Drs. Kobler and Johnson said physicians' participation in the political process is more crucial than ever, as legislators decide about the practice of medicine and health care delivery. And both advised their peers to communicate their feelings to legislators at the local and national levels. "The medical society can lobby and do all the work, but when information about the nitty-gritty, nuts and bolts of health care delivery comes directly from physicians, it really has an impact," Dr. Kobler said. "Legislators value the fact that physicians are taking time to inform and educate them."

Echoed Dr. Johnson: "Physicians have to meet their legislators in person, shake their hands and make sure they can work with them. Then they have to support them with their effort, time and finances, and talk to other doctors and put together groups of doctors [to work on political issues]. I've found that congresspeople are very interested in meeting their constituents. They'll go to medical society meetings, and Ray LaHood even came to our homes. I have no reason to think other legislators wouldn't do the same." ■

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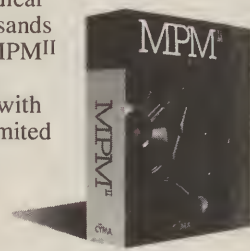
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RBRVS

(Continued from page 1)

of the effort, overhead and practice expenses and malpractice insurance costs. Like Medicare, the Blues will also use geographic practice cost indices, which compensate for differences in the cost of providing medical care in different areas. However, instead of the 16 GPCIs used in Illinois by Medicare, the Blues will use two: one for the greater metropolitan Chicago area and one for the rest of the state, Dr. Widen said.

Unlike Medicare's RBRVS, which has only one conversion factor, the Blues' RBRVS will have four conversion factors corresponding with surgical, obstetric, evaluation and management, and medicine procedures, Dr. Widen said. "We did this to lessen the impact of the RBRVS system on the payment that is allowed for the surgical subspecialists," he said. Even with the highest conversion factor, surgeons will generally receive lower Blues reimbursement under the system, Dr. Widen said, adding that reimbursement for medicine will remain the same on average, and payments for obstetric and evaluation and management services will increase.

Marketplace pressures will cause physicians to see more patients who are enrolled in the two Blues plans.

"It is true that instituting an RBRVS system will result in relatively more payment for decision-making and cognitive services — the kinds of things primary care doctors do," Dr. Widen said. "There will be a relative decrease for the procedures surgeons, particularly surgical subspecialists, perform. [The same is true] for all procedures, including some performed by internal medicine specialists. But we didn't want to move into this in a way that would change existing payment levels as radically as if we [had] used one conversion factor."

It seems the intent is to decrease the total amount of monies paid to physicians, said John Schneider, MD, an

ISMS Third District Trustee and chairman of the Third Party Payment Processes Committee. Although it appears physicians who bill for evaluation and management and obstetric care will see increases in reimbursement, it is uncertain which codes the Blues will place in the evaluation and management category, he said.

In addition, Dr. Widen said the Blues will not divulge its conversion factors; instead, physicians will receive a sample of maximal allowances for the most common procedures. Physicians will be able to extrapolate from the samples to obtain the maximal allowances for other procedures, he said. "We're still paying

usual and customary payments under our traditional indemnity plans. Traditionally, we have never revealed what the usual and customary payment is."

Although Dr. Widen and other Blues staff presented the plan to ISMS' Board of Trustees and to specialty societies before the plan was made public, Dr. Schneider said physicians could have contributed to the development of the plan.

Physicians are leery because the Blues' plan is based on the federal government's RBRVS system, Dr. Schneider continued. "The RBRVS that has been developed and implemented [for Medicare] by the federal government has not done what physicians expected it to do initially," Dr.

Schneider explained. "It has inadequacies at the present time. The conversion factors are set in an arbitrary fashion."

"We tried several different formulas for conversion factors," Dr. Widen said. "We finally came up with the ones we are using because they do accomplish all of our goals."

Although the company has no plans to expand the RBRVS payment system to other product lines, Dr. Widen predicted that marketplace pressures will cause physicians to see more patients who are enrolled in the two Blues plans. "We're seeing these lines grow very rapidly, while our traditional indemnity insurance is getting less and less." ■

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President's letter

(Continued from page 6)

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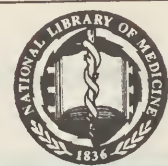
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First in a series

Managed care hits Illinois physicians

ISSUES: Access to patients, administrative practices and contracts are key concerns as managed care increases statewide. By Kathleen Furore

[CHICAGO] Managed care is quickly becoming a critical force in Illinois. According to the Illinois Association of Health Maintenance Organizations, HMO enrollment skyrocketed from 575,584 Illinois insureds in 1984 to 1,876,502 as of Jan. 1, 1994. About 30 percent of all insured Illinoisans are covered by HMOs, PPOs or other managed care plans, the association said.

MANAGED CARE

Illinois Medicine's new series will analyze the impact of managed care on physicians statewide. Future stories will provide in-depth coverage on topics such as how to keep patients in the face of managed care and how to avoid contract pitfalls.

With the penetration of managed care rapidly increasing and the number of fee-for-service patients dwindling, Illinois physicians are grappling with new and often complex issues that will ultimately affect the way they practice medicine. In this issue, *Illinois Medicine* examines the growing impact of managed care on physicians and discusses some of the broad contractual concerns physi-

cians face when deciding to participate in managed care entities.

Anxiety about access to patients is physicians' most common concern about the proliferation of managed care, said Connie Henderson-Damon, an Oak Park health care consultant and principal of the Sage Group. To thrive in the changing marketplace, physicians must re-evaluate the way they do business, Henderson-Damon said. "I see a lot of doctors putting their heads in the sand. They

(Continued on page 18)

Forum examines status of reform

DEBATE: ISMS-Kane County program explores key reform issues. By Anna Chapman

[ST. CHARLES] U.S. Rep. J. Dennis Hastert (R-Batavia) moderated a health system reform forum June 13 that provided an update on federal health system reform and an overview of problems in the current system. ISMS and the Kane County Medical Society co-sponsored the program, which was organized by Hastert and the Columbia Institute.

sion of key reform issues by physicians, health care professionals and business leaders.

"The forum comes at a crucial time," Hastert told the audience of about 275 health care workers, insurance industry representatives and constituents. He said his goal is to expand the scope of Americans' participation in the reform debate. "If people were given



Dr. Leimbach

somewhat of a decision-making process, we would not only be a more intelligent society, but a healthier society."

Hastert, a member of the House Energy and Commerce

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INSIDE

**Disaster drill
helps prepare
ER staff**

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ISMS PRESIDENT Alan M. Roman, MD (second from left), discusses the need to maintain high-quality patient care in health care reform with moderator John Callaway (right) during a roundtable televised last month on Chicago station WTTW.

Illinois physicians assume AMA leadership posts

ELECTIONS: Dr. Seward is named AMA board chairman, and Dr. Traugott joins the Council on Medical Service. By Anna Chapman

[CHICAGO] P. John Seward, MD, a family physician from Rockford and ISMS past president, was elected chairman of the AMA Board of Trustees during the association's Annual Meeting June 12-16. He assumes his new position immediately.

Dr. Seward is currently serving his second three-year term on the AMA Board.

In 1992, he was appointed to serve as an AMA commissioner to the Joint Commission on Accreditation of Healthcare Organizations. He has served on the Board's Executive Committee and was chairman of the AMA Technical Advisory Committee on Health System Reform last year.

Prior to his election to the AMA Board, he served as a member of the Illinois delegation to the AMA, beginning in 1979. He was an ISMS trustee



Dr. Seward

from 1975 to 1981 and was elected ISMS president in 1979. He first became active in organized medicine through the Winnebago County Medical Society.

Dr. Seward earned his medi-

(Continued on page 15)

Photo courtesy of Herbert Sohn, MD

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Illinois organ donor shortage increases

TRANSPLANTS: Officials say waiting list is 19-percent higher than last year's. By Rick Paszkiet

[CHICAGO] The shortage of available donor organs and tissues for transplantation has reached a crisis level, according to the Regional Organ Bank of Illinois, the federally designated organ procurement organization for northern Illinois and northwest Indiana. In ROBI's service area alone, 1,735 people are waiting for organ transplants, but only 179 donors have been identified.

"This means that the current waiting list is nine times greater than the number of organ donors last year," said Jarold Anderson, ROBI president and CEO. "We have reached the critical stage, since many of those on the waiting list will die without a transplant."

More than 100 people have been added to the waiting list since January, a 19-percent increase over last year's list. "In 1993, there were 680 organs donated for transplantation, but donations are not keeping pace with demand," Anderson said.

EHS Good Samaritan gains Level I trauma status

[DOWNERS GROVE] The Illinois Department of Public Health has approved EHS Good Samaritan Hospital as a Level I trauma center. One of 18 Level I trauma centers in Illinois, Good Samaritan will be the only such facility between Maywood and Iowa City, Iowa, according to hospital officials.

The primary difference between a Level I and a Level II trauma center is a hospital's ability to accept and respond to trauma patients immediately, according to a Good Samaritan press release. With Level I status, a hospital must have a trauma surgeon available 24 hours per day, compared with the requirement for a Level II facility that a surgeon must be able to get to the hospital within 30 minutes of a patient's arrival, the release said.

"In the field of trauma, time is critical," said Christopher Salvino, MD, medical director of the hospital's trauma program. "We observe what is called the 'golden hour,' which is best described as the time between the actual occurrence of a trauma injury and the time that definitive treatment for the injury is delivered. The more health care resources we can bring to a patient in that 'golden hour,' the better the outcome."

As a Level II trauma center, Good Samaritan has treated more than 800 patients in the past year. The hospital anticipates that within the next three years, the facility will nearly double the number of trauma patients it treats, officials said.

ROBI statistics show that the number of kidneys donated in 1992 and 1993 remained the same and the number of donated hearts increased by 4 percent and donated livers by 3 percent.

"These statistics are very disturbing," Anderson said. "For instance, the waiting list for a liver transplant increased by 41 percent in 1993. Traditionally, one-half of the children waiting for a liver transplant will die because of the lack of donated livers."

To prevent the crisis from worsening, Anderson said the public needs to become more aware of the need for donors. "Recently, we celebrated Organ and Tissue Donor Awareness Week by alerting people to the critical need for organ and tissue donors. We also keep emphasizing that transplants do work and save thousands of lives. If everyone who was a potential donor actually became a donor, the waiting list would be nonexistent."

Antidrug campaign launched

[SPRINGFIELD] More than 150 billboards across Illinois will display antidrug messages as part of a new campaign sponsored by the Partnership for a Drug-Free Illinois. The campaign is designed to focus public attention on the problem of illicit drugs and offer warnings about the dangers of drug use.

The billboards will display such messages as "Carol is the life of every party but she never remembers why" and "Joe won't make it to work today. He has the flu ... Or is it a flat tire again?"

The public awareness program is coordinated by the lieutenant governor's office and the Illinois Department of Alcoholism and Substance Abuse.



Brian Waring

CHICAGO-AREA children participate in the sixth annual Kids Run for Heart sponsored by Lutheran General Children's Hospital and the north Cook County division of the American Heart Association of Metropolitan Chicago.

Rush opens 'express lane' for ER patients

[CHICAGO] To expedite emergency room service for patients who have only minor illnesses or injuries, Rush-Presbyterian-St. Luke's Medical Center has opened a Fast Track facility. Since the program began in January, more than 100 patients have received treatment through the program for such problems as sprained ankles, chronic low-back pain and sore throats, according to Rush officials.

"The main thrust of the Fast Track program is to give better service to patients who don't have life-threatening problems by quickly moving them into a separate system," said William Wiessner, nursing and administrative director for emergency services at Rush. "Patients who can be diagnosed, treated and then discharged in 15 minutes shouldn't have to sit in the waiting room for several hours."

The Fast Track facility, which is adjacent to the emergency room, consists of two examining areas and an office for the physician and nurse who run the operation. According to Jerrold Leikin, MD, associate medical director of emergency services, the facility has quickened patient flow through Rush's emergency services department and has turned the hospital's old emergency ward into a full-service ambulatory area.

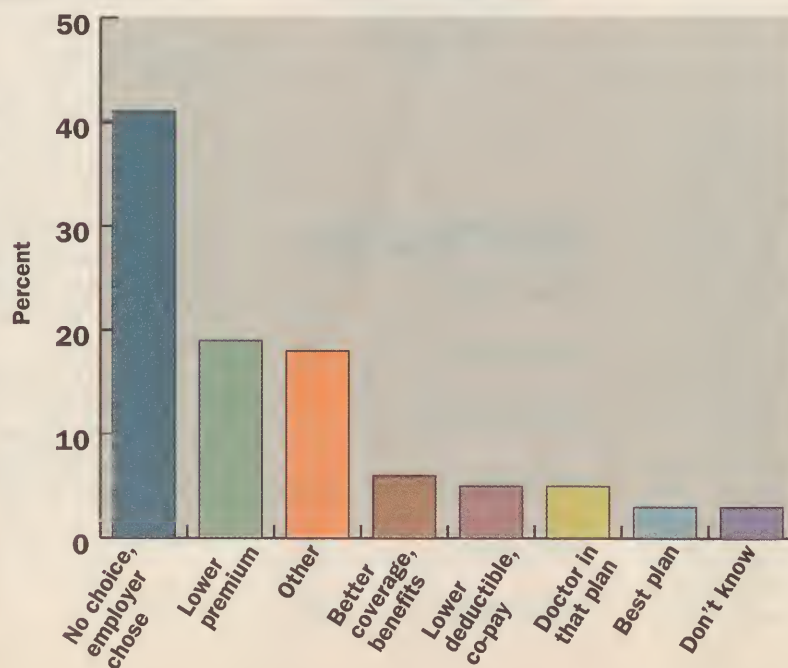
Historical society to honor businesses

The Illinois State Historical Society is looking for Illinois businesses, including medical practices and medical societies, that have been in continuous operation for at least 100 years. Those business entities identified will be recognized as part of the society's 1994 Centennial Business Program at a Nov. 11 banquet at the Palmer House Hilton in Chicago. The 10-year-old program has already honored more than 500 Illinois businesses, such as family-owned companies and international corporations, according to the society.

To nominate a business, write to the Centennial Business Coordinator, Illinois State Historical Society, 1 Old State Capitol Plaza, Springfield, IL 62701-1507 or call (217) 782-2635. Eligible businesses must be confirmed by Oct. 1 to be included in the 1994 commemorative program.

PHYSICIAN FACTS

Reasons for managed care health plan choices by consumers



Source: AMA/The Gallup Organization Inc.

Correction

In the story "County auxiliary promotes bike safety," published in the June 17 issue of *Illinois Medicine*, Paul Oltman, MD, and David Bristow, MD, were incorrectly identified. Dr. Oltman is a family physician, and Dr. Bristow is a pediatrician.

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Physicians stress putting patients' needs first

OPPORTUNITIES: Physicians and patients should make decisions together. By Anna Chapman

[CHICAGO] As the country moves toward integrated health delivery systems, physicians should be more responsive to patients' concerns and values, according to two physician participants in a June 1 panel discussion about the impact of reform on medical practice. In addition, physicians should include patients in health care decision-making, said panelists John Schneider, MD, an ISMS Third District trustee and professor of clinical medicine at the University of Chicago, and Gloria Jackson Bacon, MD, executive medical director of the Clinic in Altgeld. The panel discussion was held during the Institute of Medicine of Chicago's 79th annual meeting.

"The success of an integrated health care system will be measured by [its] ability to enable physicians to provide better care while making better use of resources," Dr. Schneider said. Physicians need to consider the significance of health care decisions for patients, he added. "What's important [to patients] is the outcome of care, dependent on the knowledge and care of the physician."

To deliver the best possible care, physicians must also commit themselves to "lifetime learning," Dr. Schneider said. To ensure quality care, physicians should begin using some form of practice guidelines or practice parameters that are scientifically sound and clinically relevant, he noted. According to ISMS policy, when practice parameters are properly developed by physicians, they may promote quality patient care.

Dr. Schneider described several different types of guidelines, including informal consensus guidelines created by a group of physicians and widely disseminated guidelines based on scientific evidence and an extensive peer-reviewed literature search. The most challenging guidelines to develop are those created through explicit technique, he explained. Those guidelines are based on scientific data analyzed by clinical experts and include the benefits and risks, outcome probabilities and the meaning of the outcome for patients. By using such guidelines, patients and physicians can make treatment decisions that meet patients' needs, he added.

Physicians should voluntarily select guidelines for their practice and customize them to reflect local practice standards, Dr. Schneider explained. "It should be the physicians – not the insurers, not the administrators, not the government agencies" – who select and implement the guidelines. "Physicians must be given not only the responsibility, but the authority, to identify the concern and deliver quality care in their practices."

FACED WITH LIMITED RESOURCES, physicians are becoming "trapped in the finances" of the current system and are being drawn away from the practice of medicine, Dr. Bacon said. Current changes in the medical marketplace will present significant opportunities for physicians, she added. Doctors will be able to focus less on financial issues and concentrate more on the service they deliver to patients and the community, she said. "We will again be purely professionals. The reason we go into medicine is to take care of people."

For 30 years, Dr. Bacon maintained a

busy Medicaid practice on Chicago's West Side, treating patients in public housing developments. Although the work has been overwhelming at times, she said she didn't quit, because she "felt that the least needed the most."

Physicians are sometimes disinclined to tackle difficult cases that are often "painful, demanding and not very rewarding," she said. But physicians can use such opportunities to "reacquaint

[themselves] with medicine. We should use the opportunity to remember how we can best serve our fellow man," Dr. Bacon added.

Federal reform bills currently being debated neglect the role of academic medical centers in education, research and patient care, according to another physician panelist, Daniel Winship, MD, dean of the Loyola University Stritch School of Medicine. And the lack of sup-

port from legislators to bolster those roles is likely to damage medical education, Dr. Winship predicted.

Most of the discussion regarding medical schools has focused on a perceived imbalance between specialists and primary care physicians, he said. Although the disparity should be addressed, it "cannot be the job of medical schools to suddenly change this imbalance."

A positive result from the move toward reform is that medical schools are changing their curricula to focus on providing care in various settings – community hospitals, clinics and group practices – not just in intensive care units, he said. ■



REPORT FOR *Illinois Physicians*

MEDICARE PART B

PHYSICIAN RESPONSIBILITY FOR ORDERING CLINICAL LABORATORY TESTS

This year the Focused Medical Review Program in Illinois Medicare Part B has identified several clinical laboratory tests that must be reviewed for possible over-utilization. This carrier is requesting that while these reviews are being conducted, Illinois physicians who order laboratory tests on Medicare beneficiaries ensure that tests ordered and reported conform to Medicare coverage policies.

Section 1862(a)(1)(A) of the Social Security Act excludes from Medicare coverage those services and procedures that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, every laboratory test ordered, even if in an automated multichannel test "profile" or organ or disease oriented "panel", must be medically justified. Moreover, no test used for screening purposes or for routinely monitoring health status is presently covered by Medicare.

The laboratory tests that are currently being reviewed for possible over-utilization are: automated multichannel tests (CPT codes 80012-80019), general health panel (CPT code 80050), lipid panel (CPT code 80061), phenytoin (CPT code 80185), ionized calcium (CPT code 82330), ferritin (CPT code 82728), glycated protein (CPT code 82985), LDL cholesterol (CPT code 83721) and immunoassay for infectious agent antibody (CPT code 86318). Medical and laboratory records indicate that physicians are ordering profiles and panels for screening purposes or for routinely monitoring health status, especially in nursing facilities. These records also indicate that laboratories are offering profiles and panels that include tests, which, unknown to physicians, are being separately billed to Medicare.

This carrier is requesting that Illinois physicians who order clinical laboratory tests on Medicare beneficiaries ensure that tests ordered are medically reasonable and necessary, and that tests reported correspond to those ordered. For reference, the carrier advises use of CPT '94.

*CPT (Current Procedural Terminology) is copyright 1994 of the American Medical Association



During a simulated disaster in Homewood in May, local paramedics prepare to transport one of several "injured" students to St. James Hospital in Chicago Heights.

Terry Vitacco

South Side disaster drill helps keep ER staff ready for action

EMERGENCY RESPONSE: Children, a fire department and a hospital participate in a crisis simulation. By Anna Chapman

[CHICAGO HEIGHTS] The Code 10 began at 3 p.m. on May 19. Fourteen children lay trapped and bleeding under furniture and debris at the St. Joseph School in Homewood. Fifteen minutes after classes ended for the day, the boiler exploded. In response to the accident, 12 ambulances, six fire engines and a

hazardous material unit were sent to the scene. St. James Hospital in Chicago Heights was notified to expect the seriously injured children to arrive at the emergency room within the hour. Fortunately, the emergency was a carefully staged disaster drill designed to test the reactions of the Homewood Fire Department and the hospital.

"St. James is getting 14 patients, which is a lot more than it normally handles," said Homewood fire chief Ray Presnak. "[The hospital staff] have to activate their internal disaster plan – call in off-duty doctors and nurses and bring a lot of people into the ER to start triaging and sorting out patients. We'll get them to the hospital alive; it's up to hospital staff from there on."

Paramedics at the disaster site stabilized the patients – whose "injuries" included broken bones, burns, loss of limbs and impalement – and began transporting them to the hospital within a half-hour of the first call. In addition to being injured, the patients were coated with a powdery substance that emitted a strange odor. As a result, decontamination had to be conducted, delaying patient transportation to the hospital.

In the ER, nurses prepped the patients. Then emergency physicians Suresh Shah, MD, and James Greene, MD, reviewed the charts and ordered X-rays, surgery or other procedures. "It's going really well," said Bill Goncher, the hospital's assistant safety engineer, after seven patients had arrived. "There aren't many people standing around. It's an effort because the ER gets crowded so quickly."

"People are aware of what has to happen and what role they play in this kind of disaster," he added. The hospital scheduled the disaster during a shift change, to test each department's effectiveness during a time of potential confusion. Four hospital staff observers recorded the workers' actions, which would later be reviewed.

St. James spent a month preparing for the disaster drill, said safety engineer Jim Skonecke. "It's an ongoing process, because we do it twice a year," he noted, adding that hospital disaster drills are required for accreditation by the Joint Commission on Accreditation of Healthcare Organizations. The hospital's other disaster drills have involved nursing home fires and tornadoes, with between seven and 25 victims. One disaster was staged at the hospital itself.

Of course, the hospital has handled real emergencies, too. Last July, a local chemical fertilizer company was struck by lightning, Skonecke said. Between 70 and 80 victims suffered respiratory problems and eye irritations. Patients were divided among several South Side hospitals, he said.

After the drill, hospital staff reviewed their roles and noted necessary improvements, Skonecke said. There had been only two minor problems – difficulty in distinguishing ER staff members, which will be rectified by giving ER nurses red badges denoting their positions, and a lack of space for notes on the disaster tags tied to the victims, he said. ■



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Bar association seminar addresses reform topics

LEGAL ISSUES: Experts discuss managed care issues including antitrust, fraud and abuse and regulatory activity. By Kathleen Furore

[CHICAGO] A panel of managed care executives, health care administrators and attorneys tackled issues of concern to physicians and lawyers during a May seminar addressing the current dynamics in health care. Sponsored by the Chicago Bar Association, the three-hour seminar emphasized the formation of health care systems and the contracting and consolidation of providers and buyers. Of most interest to medical professionals were the issues of fraud, abuse and antitrust and their relationship to managed care.

In his presentation, Michael Ile, AMA division counsel for health law, litigation and policy, called health care fraud a "big, big issue driven purely by cost containment." Ile said fraud drains the system of an estimated \$30 billion to \$100 billion each year.

The FBI and the Justice Department have made fraud and abuse the "No. 2 priority criminal enforcement issue [ranking only] behind violent crime and drugs," Ile said. In response, the FBI has added 150 agents to investigate instances of health care fraud.

Ile listed four types of conduct considered illegal under the criminal code of the Social Security Act. Three of the four – filing false claims, receiving kickbacks and rebates and making false statements – are felonies that carry five-year prison terms and a maximum of \$25,000 in fines, he noted. The fourth, violation of a participation agreement, is a misdemeanor that can land offenders in jail for six months and result in a \$2,000 fine, Ile added.

Individuals who commit health care fraud and abuse should also be aware of the civil sanctions that can be imposed on offenders, Ile said. "Civil monetary penalties for filing false claims are extremely common," he said, adding that fines can be as high as \$2,000 per false claim. "And in a quality of care review, if a peer review organization finds that you've failed substantially [to comply] in a number of cases or had a gross violation in one instance and are unwilling to comply in the future, you can be excluded from the [Medicare or Medicaid] program."

RECENT ANTITRUST DEVELOPMENTS were outlined by Jeffrey M. Teske, an attorney with Coffield Ungaretti & Harris in Chicago. Antitrust laws are the "referees of competition" in managed care, which

puts them at the heart of health care reform, Teske said. He explained that certain issues are critical to understanding the status of antitrust-relief legislation.

For example, distinguishing between vertical and horizontal agreements is key to any discussion about antitrust, Teske continued. Vertical agreements – those between entities at different levels in the distribution chain, such as doctors and hospitals – are believed to impose less antitrust risk because they don't directly restrict the independent actions of competitors. But horizontal agreements – such as those between two neighboring hospitals – can carry significant antitrust risk, especially when the entities are actual or potential competitors, he explained.

Teske also noted that the amount of market power, which he defined as the ability to raise prices above competitive levels or lower quality and/or decrease output below competitive levels, is crucial, because liability in antitrust law almost always requires proof of market power. As an example, he cited the 1992 case *U.S. vs. Alston*, the first criminal price-fixing case brought against health care professionals – in that case, dentists – in many years.

"This is a very key case from the medical community's side of things," Teske said, noting the court's ruling that "health care providers are entitled to take some joint action short of price-fixing or joint boycott to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules."

CREDENTIALING policies vary among managed care organizations, said panelist Ann Gillespie Pietrick, Chicago-based senior consultant and general counsel for the Scheur Management Group Inc., in Newton, Mass., and executive director of the Illinois Association of Health Maintenance Organizations. Pietrick said HMOs typically use more-intensive credentialing programs than PPOs, because HMOs lock members into provider networks and consequently have a higher degree of responsibility.

Several forces are moving managed care entities toward credentialing, she said, citing purchasers' demands for objective assurances about the quality of managed care networks and the potential for organizations' liability for participating providers. In addition, accredita-

tion by the National Committee for Quality Assurance, which is required by many large employer groups and by law in some states, is being applied to more managed care plans, she said.

NCQA requirements mandate that managed care organizations have written credentialing and recredentialing policies for physicians and other licensed indepen-

dent practitioners. Managed care organizations must also have a peer review entity with physician involvement to make recommendations on credentialing decisions, Pietrick said. And the organizations' staff must include MDs, DOs, dentists, podiatrists and chiropractors, she said, adding that physical therapists, psychologists and nurse practitioners may be credentialed if an organization chooses.

Recredentialing must be completed at least every two years, and managed care entities must have policies for limiting, suspending or terminating practitioner privileges, Pietrick said. In addition, organizations must establish an appeal process for adverse determinations, she noted. ■

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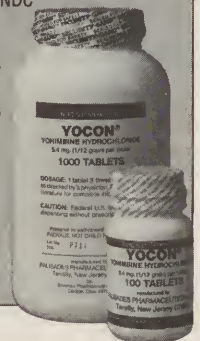
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The Lawyer Referral Network is composed of more than 60 attorneys with experience in health care. Members interested in using their services should begin by calling (800) MD-ASIST. ISMS legal staff will determine each caller's specific needs and refer him or her to an attorney who has related expertise and who will provide legal advice at a discounted rate. Possible areas for legal assistance include managed care, licensure, contracts, medical staff issues, Medicare and Medicaid, taxes, or fraud and abuse.

In addition to offering legal referral services, ISMS is developing consultant referral services. As part of its research, the Society wants to hear from members about their positive experiences with managed care consultants. To recommend consultants for the ISMS referral network, call the ISMS action line at (800) MD-ASIST. ■

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EDITORIAL

Looking beyond the label

To some members of the public, information that's labeled a "study" is automatically valid and credible. But unfortunately, some studies have neither of those attributes. During this legislative session, the Coalition for Consumer Rights, a group founded by the trial lawyer lobby, disseminated a so-called study that presents misinformation and denies the need for tort reform, including a cap on noneconomic damages in medical malpractice cases.

The coalition's study lacks credibility because it ignores certain realities. For instance, it disregards the fact that defensive medicine drives rising health care costs. And it maintains that the frequency of claims has not increased. However, that allegation is wrong because it is based on incomplete information. The study considers only the number of lawsuits filed in court. As we all know, many malpractice claims are settled by insurance companies before they escalate into lawsuits, so the study portrays an artificially low picture of the problem.

Defending claims is very costly. ISMIE closes more than 80 percent of claims with no payment to the plaintiff, and physicians defend themselves successfully in 80 percent of those cases that escalate into lawsuits. But it cost ISMIE policyholders more than \$51 million in legal and other related expenses last year to defend themselves.

The study also ignored the effect of

tort reforms passed in 1985, including the certificate of merit requirement, which made filing a frivolous lawsuit more difficult. Before the law took effect, many attorneys rushed to file suits. So the frequency of suits decreased after the law took effect, but since then, frequency has consistently climbed.

In reality, rising awards have helped increase the frequency of claims against physicians. Since 1986, the number of claims against ISMIE physicians has more than doubled, from 1,300 in 1986 to 2,800 in 1993. That is an average annual increase of 12 percent.

The study erroneously referred to reserves maintained by malpractice insurance companies as "profits." Insurance companies are required by state law to maintain reserves sufficient to pay claims to injured patients. As the amount of awards increases, larger reserves must be maintained to pay them. And those awards have almost doubled since the 1985 reforms were enacted. In 1986, the average award in an ISMIE case closed with indemnity payment was \$184,000. In 1993, it was \$350,000.

The plain truth is that the study fails to refute the need for a limit on noneconomic damages. The 1985 tort reforms were a good start, but we need to go further to control excessive litigation, defensive medicine and related costs. Caps have been effective in Colorado and California, and we need a \$250,000 cap here in Illinois.

PRESIDENT'S LETTER

Communication begins with understanding others

Alan M. Roman, MD



We have resisted attempts to make the doctor-patient relationship a medicine of strangers, an economic relationship devoid of warmth and compassion.

Under bright klieg lights in Studio A and surrounded by an audience, I eagerly counted down the final minutes to the start of the WTTW/Sun-Times panel discussion "Health Care Reform: What's in It for Me?"

Moderated by "Chicago Tonight" host John Callaway, the panel included three U.S. legislators; 12 representatives of academic think tanks, big and small business, the insurance industry and consumers; and AMA Executive Vice President Dr. James Todd and myself, representing the viewpoints of organized medicine. The collaborative project was designed to help average citizens solidify their opinions on health reform.

Unfortunately, the 90-minute roundtable, which focused heavily on policy analysis, did not offer as many opportunities as I would have liked to deliver medicine's key messages to viewers. But disappointed as I was, the rainy, rush-hour drive home allowed me to reflect on the frustrations of being a physician and the difficulties of getting medicine's viewpoint across.

For better or worse, the fundamental concept of physicians treating patients has changed dramatically. Increasingly, outside interests have interfered with the physician-patient relationship, negatively impacting our ability to deliver quality medical care with a sincere sense of satisfaction. Increasingly, utilization review and insurance company representatives with limited medical educations are making quasi-medical decisions without accountability for their actions.

Your Society has succeeded in organized medicine by assuming a leadership role in the health care debate. Your officers have melded your diverse expectations into a cogent, pragmatic approach. Our governmental affairs division is well-respected in Springfield, and our Washington Presence program has received much attention on Capitol Hill. Despite our somewhat enviable position, your Society needs your help as never before—in your office and in the political,

economic and regulatory arenas.

Patients desperately need answers to their questions and welcome our advice and expertise about health care issues, yet we offer it too seldom. Our state and federal policy-makers need our input to understand medicine's challenges so that they can better appreciate the impact of their decisions on the quality and cost of medical care. Too few of us are known to our legislators on a first-name basis, and too few belong to IMPAC.

Health care has become a political issue. Changes will occur, and we will continue to influence them. What we prefer may not be what we get, but we need to reach an agreement on reform in a way that is acceptable to the many, and we need to do it in a framework that maintains our relationship with patients and continues the quality our patients have come to expect.

I am very proud of the resiliency of our membership, which has resisted attempts to make the doctor-patient relationship a medicine of strangers, an economic relationship devoid of the warmth and compassion that are characteristic of our concerned physicians. Society as a whole can take lessons from the physicians in our organization who take time with patients who desperately need us, who spend extra hours in hospital rooms when there is so much to be done at our own homes and who work Saturdays, Sundays and nights, oftentimes with the only reward being that of making someone else feel better.

So the next time you feel frustrated and powerless to make any real changes, remember that times change, but our values are changeless. We care deeply, and we give our time, our energy and our expertise to making people's lives better. I believe in you, your officers believe in you, and if you believe in yourselves, anything is possible.

The answer to the WTTW question, What's in it for me? is clear: the best interests of our patients and the profession of medicine. What is good for them is good for me.

Quotables

"We want to make sure that in solving the health care problem, we don't rob the pension bank, or else we're going to wind up with a lot of old, healthy people living in one-room shacks."

— **Vermont Sen. James Jeffords**, *Chicago Tribune*

"The structural changes we're seeing are not being driven by fear of reform. It's a fundamental shift in power between purchaser and provider. It's not going to go away."

— **David Lawrence, MD**, CEO of Kaiser Foundation Health Plan, *San Francisco Chronicle*

"I'm just confused."

— **Kansas Sen. Nancy Kassebaum**, responding to the compromise health system reform bills emerging in Congress, *Boston Globe*

"The real issue is whether we are prepared to turn over American medicine — one-seventh of our economy — to government bureaucrats who have never succeeded in promoting efficiency and have no intention to do so. Or would we prefer to entrust it to the same competitive free market that brings food into our homes, allows us to buy automobiles and shelter and has never failed to promote both efficiency and economy? It should be an easy choice."

— **Texas Sen. Phil Gramm**, *New England Journal of Medicine*

GUEST EDITORIAL

Delay major health reforms

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As much as it pains us to say it, we believe the wisest course of action for Congress would be to delay passage of comprehensive health care reform until next year.

This isn't to say that the need to pass legislation is no longer absolutely essential. We continue to believe that until the health care delivery and financing system is reformed and all Americans are assured of coverage, medical care providers will continue to shift the costs of treating the uninsured onto employers that provide health care coverage to their workers.

Our belief that legislation should be delayed is based on one very pragmatic reason: It is simply too late in the session for Congress and the public to give such vital legislation the scrutiny it must receive.

Our fear — based, unfortunately, on past experience with benefits legislation — is that if Congress hastily enacts a comprehensive reform bill in the closing days of this year's session, many important provisions will be drafted behind closed doors by a conference committee. If that happens, neither legislators nor the public will have the time or opportunity to analyze the impact of those provisions before it is too late.

If legislators make a mistake — the odds of which increase geometrically as the congressional time clock ticks away — the consequences can be disastrous. With the nation now spending \$1 trillion a year on health care, there is no such thing as a little mistake.

Our plea for delay does not necessarily mean we are discouraged with the progress that health care reform legislation has made.

As the various reform proposals are discussed, the truly bad ideas — like mandatory health alliances — are discarded,

while good ideas are further improved. That's the whole purpose of the legislative process, and it has worked well in this country for more than 200 years.

While comprehensive health care reform legislation should be delayed for this year, Congress should not go home this fall without passing any reform legislation. Certain reforms on which there is a broad agreement — like eliminating, or at least narrowing, exclusions for pre-existing medical conditions and banning long waiting periods before coverage can begin — should be passed immediately. Such practices are a disgrace, and reform in those areas is long overdue.

We do see a danger, however, in delaying action on comprehensive reform: Delay could mean that major reforms will never be passed.

When President Clinton took office in 1993, health care, business and political leaders enthusiastically embraced the need to reform the health care system. National opinion polls indicated that the public was fed up with rising health care costs and the fact that about 15 percent of Americans had no health care coverage.

As reform has been delayed, enthusiasm has cooled. Most Americans now say that the health care system does not require major changes. Health care inflation has moderated, possibly because health care providers, pharmaceutical companies and others fear price controls and other stiff reforms.

Still, the time is right for health care reform. The health care problems in the United States are as real today as they were 18 months ago, and much of the groundwork already has been laid to make meaningful, constructive changes that will improve the quality of health care while lowering its cost.

To delay comprehensive reform until 1995 to give legislators time to analyze the various proposals is a good idea. To ignore health care reform because of a perception that the problems have passed would be a grave mistake.

GUEST EDITORIAL

As tobacco firms fib, FDA should alter the cigarette

By Anna Quindlen

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The day the leaders of the tobacco companies came to testify before Congress, you could have shot a cannonball across the long table where they sat and not hit a candid character.

One by one they temporized, fudged and waffled about two simple facts that everyone knows to be true: that cigarettes are addictive and that they cause mortal illness.

The only people in the U.S. who still deny this are the ones whose paychecks carry the imprints of the cigarette manufacturers. And even they say they wouldn't want their own kids to smoke.

That's what the top guys at the big seven tobacco companies said when they appeared recently before the House Energy and Commerce Subcommittee on Health and the Environment. They wouldn't want their own sons and daughters to do it. They were simply in the business of selling the stuff to other people's sons and daughters.

Proving that Pinocchio is only a fairy tale, Andrew Tisch, the chairman and chief executive of Lorillard Tobacco Co., was asked if cigarettes caused cancer and responded, "I do not believe that."

And his nose stayed exactly the same length, though you had to wonder whether some reasonable facsimile of Jiminy Cricket was sitting on his shoulder whispering, "Shame on you, Andrew."

But it was the tobacco execs who had the last word that day on Capitol Hill. And that word, a challenge really, came from James W. Johnston, the head of R.J. Reynolds, who said, "If cigarettes are too dangerous to be sold, then ban them."

This country has reached a plateau in its attitudes toward smoking and smokers.

Last week, when scientists once employed by Philip Morris revealed that their work on the addictive properties of cigarettes had been suppressed and their project shut down by the company, there was something a little ho-hum about the whole thing. As addictive as cocaine, one of the men opined. We know that already, don't we?

We know the answer to the question "How bad?" What needs to be asked now is "What next?"

One of the most interesting proposals comes from a clinical pharmacologist

who has been studying cigarettes for two decades. Dr. Neal Benowitz, professor of medicine at the University of California at San Francisco, envisions a special division of the FDA that would set ever-decreasing levels of nicotine in cigarettes over, say, the next 20 years. An entire generation of Americans gradually could be weaned from the drug.

And the next generation might never acquire an enduring habit.

"Kids begin to smoke, and over two or three years they become addicted," says Benowitz. "They say, 'Oh, I'll just smoke for a while, and then I'll stop.' And then they discover that they can't. They start out smoking for social reasons but wind up smoking for pharmacologic reasons. Low-nicotine cigarettes could change that."

Dr. David Kessler, FDA commissioner, has shown a laudable willingness to confront the reality of tobacco use and its pernicious effect on the health of Americans. Now he must guide the government in a new plan of action, now that virtually all the world knows how dangerous tobacco is and much of that world has been declared off limits to smokers.

The canny Johnston raised the specter of prohibition because it is simultaneously disturbing and logical.

If cigarettes are as dangerous as we know they are, they ought to be banned. If they are banned, it causes monumental problems ranging from the inevitable black market to the plight of those who became addicted when the stuff was still legal.

But if his challenge was the tobacco companies' version of "think globally," perhaps government should begin to think about the second part of that dictum and to act locally, on the product itself.

It's always fun to harass the tobacco companies, disingenuous as they are about what they do and how they do it. Tobacco taxes, advertising bans, counter-advertising and the like will continue to be valuable tools in treating tobacco like the dangerous drug it is.

But if the point really is to save lives, then surely one way to go is to focus on the cigarette and to make it, as Benowitz suggests, less lethal.

Certainly it is one of the several sensible suggestions that Kessler and all the other activists who campaign against tobacco should consider as we move from education, censure and curtailment to some new second stage in the tobacco wars.

LETTERS

More information sought about opera composer book

As an opera lover, I was glad to see your article "Opera on the Couch," about Dr. Eric Plaut's book on opera and its composers, which appeared in the May 20 issue of *Illinois Medicine*.

However, you did not include any additional references for this book, such as the publisher, the date of publi-

cation and the price. Perhaps you should consider publishing that information, since others might want to buy the book or find it at their local library.

Frank Norbury, MD
Jacksonville

Editor's note: Grand Opera: Mirror of the Western Mind by Eric A. Plaut, MD, was published by Ivan R. Dee Inc., Chicago, copyright 1993. The cover price is \$28.50.



Demonstrating some of the new sun-safety guidelines promoted by physicians, Robin Wetzel applies sunscreen to her daughter, Brittany, during a May press conference.

Brian Waring

Physician groups release sun-exposure guidelines for kids

UV PROTECTION: Doctors say simple precautions can prevent skin cancer later in life. By Kathleen Furore

[CHICAGO] During a sun-drenched Chicago press conference in May, physicians issued warnings about the dangers of sun exposure for children. They also described new sun-safety guidelines for kids and their parents released by the

AMA, the American Academy of Pediatrics, the American Academy of Dermatology and the American Society of Plastic and Reconstructive Surgeons.

"At least one out of every six children today will develop skin cancer during their lifetime," said William Jacott, MD, a family physician and a member of the AMA Board of Trustees. He explained that before the age of 20, individuals are exposed to 80 percent of the dangerous ultraviolet radiation they will absorb over the course of their lives. "But we are here to announce good news. Skin cancer is almost entirely preventable through simple and inexpensive precautions. If we begin early to educate and protect our children, we can reduce the incidence of skin cancer by 78 percent."

"Children spend about three times as much time in the sun as adults," said Marge Hogan, MD, a fellow of the American Academy of Pediatrics. "The object is to teach children and their parents to avoid excessive sun exposure and start protecting them during infancy."

From 1950 to 1989, the incidence of malignant melanoma increased by 321 percent, and since 1973, melanoma cases have steadily increased by about 4 percent per year, according to an AMA fact sheet. Of the 700,000 new cases of skin cancer diagnosed in the United States in 1994, 32,000 will be malignant melanoma.

Although the sun guidelines are targeted at parents, the four medical groups are enlisting the help of their physician members to help spread the word, Dr. Jacott said. "The best health care physicians can offer patients is prevention." Through patient education, doctors can keep three out of four of their patients from developing skin cancer, he added. Physicians will receive the guidelines and are encouraged to make copies of them for their patients, Dr. Jacott noted.

To help protect children, the guidelines offer parents the following advice:

- Keep infants, especially babies under 6 months old, out of the sun.
- Avoid sun exposure between 10 a.m. and 3 p.m.
- Use a sunscreen with a sun protection factor rating of at least 15.
- Make sure that carriages have hood attachments. For infants and toddlers, use a stroller with a canopy. Children should also wear hats and light-colored clothing.
- Beware of reflected light and cloudy days, since as much as 80 percent of the sun's radiation passes through clouds.
- Be careful when taking certain medications such as tetracycline, which can cause a reaction when individuals are exposed to the sun.
- Have children wear sunglasses with lenses that absorb 100 percent of UVA and UVB light.
- Examine skin regularly for unusual growths, itchy patches, sores that do not heal and changes in moles or colored areas.
- Avoid tanning parlors.
- Set a good example for children by following these rules.

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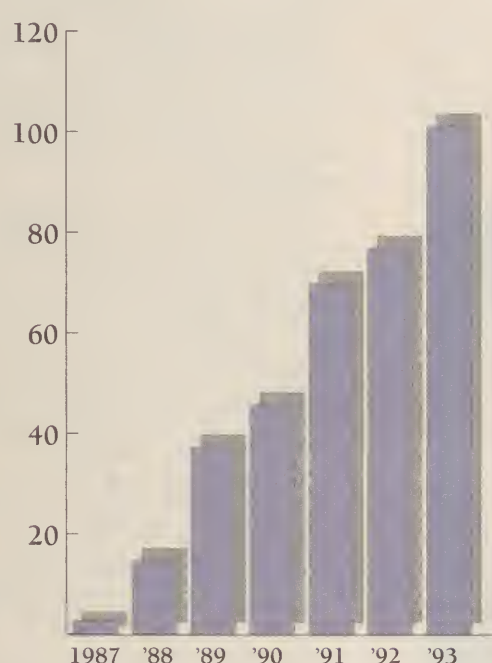
ISMIE Update

Consumer group
releases study
misrepresenting
frequency
of malpractice
claims

PAGE 6

Increase in reported ISMIE claims, 1987-93

Percentage increase from 1986, by year



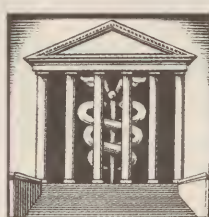
Source: Illinois State Medical Inter-Insurance Exchange

Case in Point

Finger-pointing damages defense

By Kathleen Furore

When more than one physician is named in a malpractice lawsuit, partners and consulting specialists may be among the defendants. And because conflicting



interests often exist, defendants sometimes engage in finger-pointing, each blaming the other for actions that may have caused the litigation. But as the following cases illustrate, trying to shift the blame makes defending a malpractice suit very difficult and usually results in a finding for the plaintiff.

Case #1

The case in brief: In early 1987, an Ob/Gyn found a mass in a breast of one of his regular patients and recommended a mammogram. The doctor saw the patient two weeks later but failed to ask whether she'd had the mammogram. In fact, the patient did not have a mammogram until three months after the initial recommendation. The mammogram revealed three lesions, and the radiologist mailed a copy of his findings to the referring physician and placed copies of the results in the files of the hospital and radiology department.

The Ob/Gyn did not see the patient again until early 1988, at which time he noted that the

mass had grown. He again recommended a mammogram, but it was not performed until seven months later. A different radiologist reviewed the patient's mammogram and found the mass highly suspicious with "remarkable interval changes" from the 1987 mammogram. He called the treating Ob/Gyn to report the findings.

Although the patient underwent a radical mastectomy, she ultimately died from advanced-stage carcinoma. Her estate sued the Ob/Gyn and the radiologist who had read the first mammogram for failure to follow up on the results of the first film.

After the suit was filed, the physicians began accusing each other for actions that may have caused the litigation. But as the following cases illustrate, trying to shift the blame makes defending a malpractice suit very difficult and usually results in a finding for the plaintiff.

(Continued on page 10)

MALPRACTICE ROUNDUP

Removal of healthy ovary results in criminal charge

In the first case of its kind in London, a woman whose healthy ovary was removed without her consent is filing criminal charges against her surgeon, according to a story in the *Chicago Tribune*. The patient entered the hospital for a hysterectomy and an exam of a cyst on her right ovary. Although she gave permission for the right ovary to be removed if its condition had deteriorated, she specified in writing that she did not want the left ovary removed. But during the procedure, the physician removed both ovaries, the story said.

In addition to filing charges of assault and battery against the physician, the woman's attorney may file a separate civil claim against the hospital at which the operation was performed, according to the article.

This case is unique because it is the first that involves criminal charges against a physician, the story said. But it is just one of many incidents in London in which women have claimed that their reproductive organs were removed without consent or that they lost unborn babies during routine operations. For example, national prosecutors may press charges against a physician for removing the womb of a woman during surgery to treat her endometriosis. The physician aborted a fetus during the surgery, even though the woman didn't know she was pregnant.

In the United States, removal of reproductive organs without patient consent is common and has resulted in a number of civil claims, according to Nora W. Coffey, president of the Philadelphia-based Hysterectomy Educational Resources and Services Foundation, who was quoted in the article. She said, however, that she is unaware of any criminal cases filed in this country against physicians for such procedures.

Physicians must specify risks

To obtain informed consent, a physician must explain the specific material risks of a procedure, according to a decision handed down by the Rhode Island Supreme Court. It is insufficient to state in general terms that any procedure imposes risks, the high court ruled.

In *Medeiros vs. Yashar*, a thoracic surgeon performed pericardiocentesis on a patient who had been admitted to the hospital with a diagnosis of pericardial effusion. During the diagnostic test, in which a needle is used to take a sample of fluid in membranes around the heart, the needle punctured the patient's heart muscle. The puncture caused bleeding and loss of blood pressure, and emergency surgery was performed.

Although the operation proved successful, the patient sued the surgeon for negligence in performing the test and failure to obtain informed consent. The physician was granted a jury verdict on the negligence claim but was found liable for failure to obtain

informed consent. In spite of his contention that his policy was to warn patients that there may be risks and complications with any procedure and that he would answer any questions the patients had, the court noted that the doctor failed to specify the risks of pericardiocentesis. The court also concluded that a lecture the surgeon said he routinely gave patients about mortality and morbidity was "confusing and uninformative" and insufficient to allow the plaintiff to give informed consent for the procedure.

Risks in CVS testing

Chorionic villus sampling – a test commonly used in the first trimester to diagnose fetal genetic disorders – is regarded as reasonably safe by the medical community. But according to an article in *Medical Malpractice Law & Strategy*, CVS carries risks that create potential liability for physicians performing the procedure.

According to the article, evidence suggests a greater risk of fetal loss and/or fetal abnormality with CVS than with amniocentesis. It also notes that CVS has a higher false-positive rate for some chromosomal/genetic disorders than does amniocentesis, fails to identify neural tube defects the way analysis of amniotic fluid alpha-feto protein does and can lead to miscarriage or, more commonly, cause hemorrhage and/or hematoma formation.

Case in Point

(Continued from page 9)

other. The Ob/Gyn claimed he never received the report regarding the first mammogram. The radiologist's files, however, indicated the records had been sent to the correct address. And the radiologist claimed phoning the physician was unnecessary, since the findings at the time weren't life-threatening.

The radiologist met the applicable standard of care, but the cases against both doctors had to be settled because of their finger-pointing.

Case #2

The case in brief: In July 1989, the patient phoned her primary care HMO physician, an internist, after she discovered a pea-size lump in her breast. The patient had never seen the physician. After discussing the lump and the patient's irregular menstrual bleeding, the internist referred her to an Ob/Gyn. The patient scheduled an appointment, presenting with a complaint of irregular bleeding.

The Ob/Gyn prescribed medroxyprogesterone acetate and recommended the patient have a mammogram, which was

scheduled through the internist's office for early August. After phoning to notify the internist's office that she'd had the mammogram and that the results were available, the patient failed to follow up further — even though she heard nothing from the internist's office regarding her mammogram. By December 1990, the lump had grown to the size of a walnut.

In April 1991, the patient was treated by a third physician for an unrelated complaint, and a CT scan revealed breast cancer. She underwent chemotherapy, radiation and a radical mastectomy and subsequently sued the HMO internist

and the Ob/Gyn for failing to diagnose the cancer in 1989, which she alleged shortened her life expectancy.

The internist denied responsibility for the patient, saying he'd never seen her, had no records for her and was never involved with her care or treatment. He couldn't explain why hospital records from the 1989 mammogram contained his name. But the Ob/Gyn said that after detecting the patient's breast lump, he phoned the internist to order a mammogram, which under the HMO's guidelines could be ordered only by the patient's primary care physician.

Because the physicians engaged in finger-pointing, consultants were unable to determine who was telling the truth. The case was settled in favor of the plaintiff.

The points these cases make: Regardless of how defensible a physician's actions are or who is telling the truth, juries historically rule against all defendants involved in instances of finger-pointing, according to attorneys who have litigated those types of malpractice cases. Finger-pointing can be devastating to a defense, said Kevin Glenn, senior partner at Chicago's Bresler, Harvick and Glenn Ltd.

"Most doctors are defense-minded," Glenn said. "Their first thought is, 'None of us did anything wrong.' But once defendants do begin accusing each other, they eliminate one of the tasks of the plaintiff's attorney, which is to get testimony critical of the defendants. When you have expert testimony from someone who isn't interested in helping the plaintiff — someone whose testimony is not bought and paid for — it's impossible to overcome. And we lose."

Bob Baron, a malpractice attorney with Rooks, Pitts & Poust in Joliet, concurred. "There is a general feeling among most defense attorneys that it's not a good idea to let a jury know that some part of the health care system has failed," Baron explained. "Many times, if there's an argument, the jury is likely to say, 'Hold them both liable and split the amount [of damages].'"

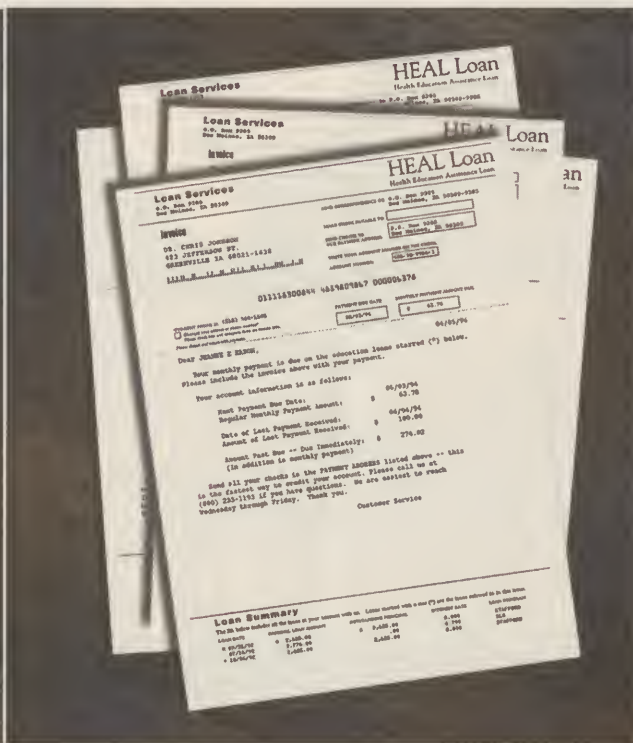
Baron added that malpractice suits may result when physicians point fingers at other health care workers in patient records. He advised physicians to be objective when documenting their patients' care. "The example I often give is of a doctor who makes a note in his record that says, 'I came in this evening, and no one from the medical staff was to be found,' or 'I was disappointed with what nurse so-and-so did.' Those are the kind of side comments that can lead to lawsuits. And how can a physician back away from something that's in the records? At best, he may be called as a witness; at worst, named as a defendant."

From a physician's standpoint, shifting blame is an understandable temptation considering the possible ramifications of a malpractice lawsuit. But as Joliet internist Wayne Kassel, MD, said, "It's a human impulse you have to put down."

"I'm sure physicians get pretty scared. And fear could drive them to say, 'If I blame someone else, it will make me look better,'" continued Dr. Kassel. "I haven't been involved in [that] kind of case personally, but I think you have to strive to defend yourself and your point of view and not necessarily help convict someone else of wrongdoing. You shouldn't become a witness for the plaintiff."

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OBITUARIES

Former *Illinois Medical Journal* editor dies

Theodore Van Dellen, MD, editor of the *Illinois Medical Journal* from 1960 to 1976, died June 17 in St. Petersburg, Fla., at the age of 82. The journal was the predecessor of *Illinois Medicine*.

Dr. Van Dellen was a Chicago internist and cardiologist and earned his medical degree from Northwestern University Medical School in 1936. During his career, he held several faculty and leadership positions at Northwestern, including assistant dean, associate professor of medicine and director of the Florsheim Heart Clinic. He retired in 1977.

In addition to holding academic positions, Dr. Van Dellen participated in organized medicine. He joined ISMS in 1939, was a delegate to the AMA House of Delegates and served as president of the Chicago Medical Society from 1960 to 1961.

Dr. Van Dellen was best known for the "How to Keep Well" column he wrote for the *Chicago Tribune* for more than 30 years. According to the *Tribune*, the column of health tips was so popular that in one year he received nearly 200,000 letters. His syndicated columns, including "Keep Your Child Well," which he began writing in 1959, appeared in 100 newspapers in the United States, Puerto Rico and Canada. He also won numerous awards for his medical writing and educational efforts. ■

* Indicates member of ISMS Fifty Year Club

*Balkin

Ruth B. Balkin, MD, a pathologist from Highland Park, died April 13, 1994, at the age of 81. Dr. Balkin was a 1937 graduate of Rush Medical College, Chicago.

*Fial

Thaddeus C. Fial, MD, a general practitioner from Oak Lawn, died April 25, 1994, at the age of 77. Dr. Fial was a 1943 graduate of Chicago Medical School.

Laker

Harold I. Laker, MD, an otolaryngologist from Evanston, died Feb. 11, 1994, at the age of 65. Dr. Laker was a 1954 graduate of the University of Toronto Faculty of Medicine, Ontario.

*Reich

Walter J. Reich, MD, an Ob/Gyn from Highland Park, died May 15, 1994, at the age of 89. Dr. Reich was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

*Yellen

Harry J. Yellen, MD, a cardiologist from Northbrook, died April 2, 1994, at the age of 82. Dr. Yellen was a 1937 graduate of the Loyola University Stritch School of Medicine, Maywood.

IDPR DISCIPLINES

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

February 1994

Ruth S. Campanella, Chicago – physician and surgeon license reprimanded and fined \$5,000 after failing to possess an Illinois controlled substance license.

Kenneth L. Gill, Worth – physician and surgeon license and controlled substance license placed on probation for two years and fined \$2,000 after allegedly prescribing Schedule IV controlled substance drugs nontherapeutically to a patient.

Ralph Kenck, Oak Park – physician and surgeon license placed on probation for three years after being disciplined in the state of Montana.

Thomas Maibenco, Chicago – physician and surgeon license indefinitely suspended due to a mental illness that impairs the ability to practice.

Ramesh Patel, DuQuoin – physician and surgeon license placed on probation for two years; controlled substance license suspended for 90 days followed by probation for three years after allegedly prescribing controlled substances nontherapeutically.

Sung Taek Suh, Orland Park – physician and surgeon license reprimanded and fined \$500 for failing to notify the department of an adverse action taken against him by a governmental agency.

Mahendra Udani, Johnson City – physician and surgeon license indefinitely suspended for a minimum of five years after being disciplined in the state of California.

March 1994

Leonard Charles Arnold, Chicago – physician and surgeon license placed on probation for two years; controlled substance license indefinitely suspended after prescribing a controlled substance for nontherapeutic purposes.

Renuka Bajaj, Charleston – physician and surgeon license reprimanded and fined \$5,000 due to unprofessional conduct.

Irvin L. Blose, Jacksonville, NC – physician and surgeon license indefinitely suspended for a minimum of five years after being disciplined in the state of Kentucky.

John A. Coe, Benton – physician and surgeon license reprimanded due to dishonorable, unethical and unprofessional conduct.

Ester Pimentel, Darien – physician and surgeon license placed on probation for two years for alleged fraudulent billing and lack of quality of care rendered.

Scott Sickbert, Colorado Springs, CO – physician and surgeon license indefinitely suspended for a minimum of five years after being disciplined in the state of Colorado.

Ramon Walczynski, Niles – physician and surgeon license indefinitely suspended due to a physical illness resulting in the inability to practice.

April 1994

Antonio M. Alandy, New York, NY/Eureka, SD – physician and surgeon license indefinitely suspended after being disciplined in the state of New York.

Alieh Arjmand, Chicago – physician

and surgeon license reprimanded and fined \$1,000 after allegedly changing the dates on an initial visit of a patient in order to ensure insurance coverage.

Charles F. Eddingfield, Carthage – physician and surgeon license placed on indefinite probation after being disciplined in the state of Iowa.

Richard Gaynor, Lombard – physician and surgeon license suspended for 90 days followed by probation for five years; controlled substance license revoked after being disciplined in the state of Louisiana.

Narendra Kumar, Modesto, CA – physician and surgeon license indefinitely suspended for a minimum of five years after being disciplined in the state of California.

Ignas Gediminas Labanauskas, Chicago Ridge – physician and surgeon license placed on probation for five years and fined \$65,000 after charging excessive fees to his patients and engaging in unbundling in his billings.

Harold Schmidt, Greenwood, SC – physician and surgeon license placed on indefinite probation after being disciplined in the state of South Carolina.

Teodoro A. Texidor, Chicago – physician and surgeon license placed on probation for two years and fined \$2,000; controlled substance license indefinitely suspended after prescribing for nontherapeutic purposes.

May 1994

Pritam Sahni, Mount Vernon – physician and surgeon license reprimanded; controlled substance license placed on probation for one year after allegedly failing to maintain an accurate record of controlled substances dispensed.

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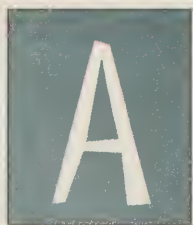
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FAMILY VALUES

Preventing child abuse through education

Mount Sinai's Parenting Institute teaches the skills needed to raise a family.

BY KATHLEEN FURORE



At first glance, the students listening attentively to an instructor look like students you'd find in any high school or college lecture hall. But this isn't just any high school or college class. And the 14 students assembled in Glasser Auditorium at

Mount Sinai Hospital Medical Center in Chicago on this steamy June night aren't typical students. They're all parents or prospective parents enrolled in the hospital's Parenting Institute – a year-old program designed to curb the rising incidence of child abuse and neglect by teaching the skills needed to raise a family.

"In our area [the Lawndale neighborhood on Chicago's West Side], we have one of the highest numbers of abuse reports in the nation, and we feel that it's because so many parents don't understand the developmental aspects of children," said Padmanabhan Mukundan, MD, chairman of Mount Sinai's new family medicine department and medical director for the Sinai Family Health Centers, a 13-site community-based clinic system.

"At [Mount] Sinai, we have some unique problems," he continued. "Twenty percent of the babies born here, and almost 40 percent of those in our neonatal intensive care unit, show positive for substance abuse. We also have a lot of teen moms and premature babies. These parents need someone to teach them in simple terms about a child's developmental phases and about the skills they'll need to raise their children. The Parenting Institute is a strong asset. As important as what we do [medically] inside the hospital is what they teach mothers and fathers."

The parenting classes can benefit any parent or parent-to-be, according to program manager Carolyn Vessel. "Statistics show that it's not only the poor who are abusing children, but also people going to work every day. We like to call the institute the great

equalizer, because everybody needs it. We all should be lifelong learners."

THE CLASSES, which combine lectures, group discussions and role-playing exercises, were developed and are taught by professionals ranging from child development specialists and communication trainers to nurses and physicians, according to Vessel. Topics include child development, discipline, children's health, nutrition, education, single and teen parenting, stress management, family abuse prevention and parent resources, she noted.

"Our ultimate goal is prevention [of abuse] rather than intervention [once abuse has occurred]," Vessel explained. "As I always say, good parents aren't born, they're made. And maybe we can even stop some people from having kids too soon. I've heard so many students say, 'You know, if I had known all this, I would have waited.'"

Although the Parenting Institute is open to students from all walks of life, many who take the core curriculum offered in the intensive, two-semester, 6-month program are young, inner-city men and women with troubled pasts. In the 1994 summer session – the fifth since classes began in 1993 – some students are cuddling babies while taking notes on the importance of setting rules and limits.

Attendees, whose names have been changed for this story, have different reasons for their participation. Jenny is a former substance abuser who entered the class voluntarily so that she could be a better mother to her young son. Tina's attendance was mandated by the Department of Children and Family Services. Tony is an unmarried father fighting for custody of his child. Judging from their comments, though, they have something in common: They're absorbing the lessons designed to help them overcome their problems and become effective moms and dads.

FAMILY VALUES

"We have to teach our kids that just because they're around [profanity and violence] doesn't mean they have to do it," said Jenny, who is now actively involved in her son's school program. She added that she feels "real blessed, real happy with myself now that there are no drugs."

"When we put our kids down and others put them down, it gets in their spirits and they begin to live it," said Tina. "Everything revolves around commitment. And I would like to say to my classmates: We are all parents becoming committed to our society and our children, and I like that in you."

TAKING THE PROGRAM seriously and demonstrating that they've learned from their experiences are musts for Parenting Institute students. They can miss only two classes each semester and must make them up to graduate, said Vessel.

For students who need financial assistance for the \$350 course, help is available, according to Vessel. DCFS covers the costs of students it sends to the institute, and payment plans and a sliding-fee scale based on income are available. Some students receive scholarships to help fund their enrollment, but they risk losing financial assistance if they fail to attend classes regularly.

Before and after completing the institute's core curriculum, each student must also complete a child abuse prevention inventory test, which was developed by the National Committee for the Prevention of Child Abuse, said Vessel. "This measures where they were when they started, how great their potential for abuse was and where they ended."

Students who successfully complete the program receive a certificate of achievement and a resource

notebook containing research and information about each topic presented in class.

Although Dr. Mukundan said the institute hasn't existed long enough to monitor results clinically, he expressed confidence that it is meeting its goals. "We instinctively feel, even without scientific results, that this is a step in the right direction. These mothers and fathers really need a sympathetic education, and they're learning the skills they need to be good parents."

As it prepares to celebrate its first birthday this fall, Mount Sinai's Parenting Institute is poised to expand into other inner-city neighborhoods and beyond. In late June, classes began at St. Sabina Church on Chicago's South Side. Dr. Mukundan said representatives are talking to other hospitals, working with city colleges and soliciting corporate sponsors so that the Parenting Institute can branch out.

Dr. Mukundan and Vessel also noted their willingness to help any community interested in implementing a program like the Parenting Institute. The curriculum can be adapted to meet any hospital's or organization's specific needs, Vessel said.

"The problem of abuse is not just an inner-city problem or a poverty-related problem. It cuts across all cultures, economic strata and demographic areas," Dr. Mukundan said, suggesting that physicians in rural and suburban as well as inner-city neighborhoods become involved in the parenting education process. "Physicians, especially in rural areas, are role models," he concluded. "And the role doctors play in children's lives today is so complex. The problems are so different than they were 20 years ago. Physicians should take advantage of these kinds of [nonmedical] services that can help complete the cure." ■



John McNulty

AMA maintains health system reform policy

ANNUAL MEETING: Delegates vote to continue working toward universal coverage and access. By Kathleen Furore

[CHICAGO] To help maximize the association's influence on health system reform legislation, the AMA House of Delegates voted last month to allow its Board of Trustees to continue implementing AMA policy aimed at providing universal coverage and access. The action was taken during the AMA's Annual Meeting June 12-16 in Chicago.

After debate in reference committee and on the House floor, delegates decided to give the AMA Board the flexibility to continue its participation in health system reform. Specifically, they endorsed an approach that blends employer and individual responsibilities for buying health insurance and supports health care IRAs. In addition, individuals should be able to choose and own their health insurance, according to AMA reform policy. The House also adopted a recommendation encouraging the development and use of health savings accounts as an integral component of the AMA's advocacy efforts aimed at achieving universal coverage for Americans. And although the House adopted a substitute resolution stating that the AMA will declare its strong support for those elements of health system reform proposals that are consistent with AMA policy, delegates also voted to allow the AMA to support health system reform bills that do not include every component of AMA policy on reform.

Delegates did not adopt ISMS-sponsored resolutions calling for the AMA to oppose President Clinton's health plan in its current form and to reject employer

mandates for providing health insurance. During debate in support of the measures, several physicians, including some from Illinois, expressed their concerns that the president's plan would increase bureaucracy and interfere with the physician-patient relationship. But the House voted to maintain the flexibility that would enable the AMA to provide input into all legislative proposals and to push for inclusion of AMA-acceptable language in whatever reform package ultimately passes.

"If you took a poll of doctors, they're 95 percent opposed to the Clinton plan," said Jerald Schenken, MD, an AMA trustee from Nebraska, as reported in *USA Today*. "But that wasn't what the vote was."

ISMS President Alan M. Roman, MD, noted that ISMS passed policy in 1992 endorsing a health system reform plan that included employer mandates. However, the ISMS House of Delegates reversed its position on mandates after further study on the issue, he said. "Though we came, discussed and argued that position [at the AMA meeting], we didn't carry the day. But Illinois leadership recognizes that this is a unified state and enthusiastically will support the AMA's Board of Trustees and House of Delegates in promoting present policy."

The issue of a single-payer system also stimulated debate among the delegates. Some physicians said they support the concept of single-payer systems and called for the Board to continue evaluating variations of those systems just as it



Dennis Brown, MD, an ISMS Third District trustee and Illinois delegate to the AMA, considers a reference committee report during the AMA Annual Meeting in Chicago last month.

evaluates all other approaches to reform. But debate on the House floor mostly opposed single-payer systems, and the House voted to reaffirm current AMA policy stating that those systems are not in the "best interest of the public, physicians or the health care of this nation and should be strenuously resisted."

IN A REPORT examining single-payer health system reform plans, the AMA Board concluded that "such systems fail to provide adequate and timely urgent and elective services, encroach upon physician autonomy and the patient-physician relationship, are not responsive to technology changes, have not stabilized spending and incur many of the same administrative costs as multiple-payer systems."

In further action, the House of Delegates passed a reference committee recommendation to support current AMA policies regarding antitrust relief and

freedom of choice for patients and physicians. Acting on those policies, the AMA has lobbied for federal legislation to cap noneconomic damage awards in malpractice cases and has developed grassroots support for the Health Care Antitrust Improvements Act of 1993, an antitrust measure that allows doctors to seek certificates of review from the U.S. attorney general for certain collaborative efforts.

In addition, the AMA has successfully lobbied for the adoption of two amendments by the U.S. House Ways and Means Health Subcommittee. One directs the secretary of the U.S. Department of Health and Human Services to develop regulations banning insurance companies and managed care organizations from forbidding physicians to discuss treatment options with their patients. The other deletes provisions that would have created a federal physician recertification program. ■

AMA House of Delegates acts on public health issues

ANNUAL MEETING: Physician leaders adopt efforts to curb violence and smoking.

By Anna Chapman

[CHICAGO] Discussions of policies on smoking and violence dominated debate about public health issues during the AMA Annual Meeting June 12-16. The AMA House of Delegates acted on eight tobacco and smoking-related resolutions, including one encouraging state and county medical societies to publicize the names of political candidates who accept gifts or contributions from the tobacco industry.

The reference committee report on that resolution noted that it is "reprehensible for members of Congress to accept gifts or contributions from the tobacco industry." During floor debate, members of several state delegations also called for stronger limits on tobacco availability, cuts in tobacco subsidies and increases in tobacco taxes. Ultimately, the House concurred with the reference committee recommendation that legislation should be sought at the local and state levels.

Delegates also rallied behind a resolution urging all restaurants and convenience stores to "immediately create a smoke-free environment." In addition, the House decided to recognize and commend restaurant chains that have already banned smoking in their franchises.

In other smoking-related actions, the House adopted a resolution directing the AMA to study a California initiative that raised excise taxes on tobacco products and resulted in a decrease in smoking three times the national rate. In addition, delegates voted to tell organizations representing sports figures that the use of tobacco products during public athletic events is unacceptable. "Tobacco use by role models sabotages the work of physicians, educators and public health experts who have striven to control the epidemic of tobacco-related disease," according to the substitute resolution adopted by the House.

Physician delegates also voted to

encourage a smoke-free military environment and to create writing awards for articles addressing tobacco-related disease. To be eligible, the articles must appear in publications that carry tobacco advertising.

Resolutions addressing violence also received considerable support in reference committee and on the House floor. Delegates adopted a resolution directing the AMA to continue working with the AMA Alliance to reduce family violence and maintain violence prevention as a "centerpiece public health issue for the federation." The AMA's National Coalition of Physicians Against Family Violence already has more than 6,000 members, the resolution stated.

A Board of Trustees report on mass media violence and movie ratings was adopted in lieu of two resolutions with similar intent. The report reviews current scientific literature regarding the relationship between children's exposure

to violence in the media and aggressive behavior and attitudes. It recommends that the AMA urge the entertainment industry to change its rating system "to give consumers more precise information about violent and sexual content of motion pictures, television and cable television programs and other forms of

Tobacco use by role models sabotages the work of physicians, educators and public health experts who have striven to control the epidemic of tobacco-related disease.

video entertainment." A new rating system could incorporate age classifications to reflect "scientifically demonstrated developmental periods during childhood and adolescence," the report said.

(Continued on page 15)

Public health issues

(Continued from page 14)

The House referred to the Board for decision a resolution calling for the establishment of a task force on gun control. As proposed in the resolution, the task force would include groups interested in gun control and the National Rifle Association. The resolution also asks for the creation of model legislation targeted at curbing gun-related violence.

To help reduce head injuries sustained in bicycle accidents, the House adopted a resolution encouraging physicians to donate at least one bicycle helmet for

local distribution every year. The resolution also asks the AMA to invite the other health organizations and the American Bar Association to participate in helmet distribution programs.

In addition, delegates modified existing AMA policy on helmets. Specifically, the House directed that a provision be added to model state and local legislation requiring companies that rent bicycles to offer helmets to all riders and passengers.

Among the other actions taken on public health issues was a reaffirmation of support for the National Vaccine Injury Compensation Program. Physicians said the program has stabilized the vaccine

supply and removed vaccine-related injury claims from the tort system. In a report to the House, the Board recommended that the AMA work to ensure that the program maintains a rational scientific basis for just compensation.

In addition, the House adopted a substitute resolution asking Congress to conduct an “urgent” cost-benefit analysis of the U.S. Occupational Safety and Health Administration’s regulations on blood-borne pathogens. The original resolution said the current regulations are arcane and include “burdensome record-keeping and time-consuming courses, which cover long-accepted medical practice.” ■

Elections

(Continued from page 1)

cal degree from the University of Illinois College of Medicine in 1965 and completed his residency at the Mayo Clinic. He served as Winnebago County coroner for 19 years.

IN ANOTHER VICTORY for Illinois, ISMS immediate-past President Arthur Traugott, MD, was elected to the AMA Council on Medical Service. “From the bottom of my heart, I want to thank you for your vote and diligence,” Dr. Traugott told the House of Delegates after the election results were announced. He also thanked the ISMS delegation and the Great Lakes Coalition for their support during his campaign.

An Urbana psychiatrist, Dr. Traugott was elected ISMS Eighth District trustee in 1982. For six years, he served as chairman of the ISMS Third Party Pay-

ment Processes Committee and most recently was chairman of the ISMS Ad Hoc Committee on Health System Reform. The ad hoc committee developed a state plan to educate physi-



Dr. Traugott

cians, patients and the public about reform issues important to medicine. In addition to the many ISMS committee positions he has held, Dr. Traugott has served as an AMA delegate since 1982.

He earned his medical degree from the University of Kansas School of Medicine in 1967 and has been an assistant clinical professor at the University of Illinois College of Medicine in Urbana since 1979.

IN OTHER AMA election results involving Illinois physicians, Alfred Clementi, MD, chairman of the ISMS Board of Directors, was elected vice chairman of the AMA Council on Long-Range Planning and Development. He is a general surgeon in Arlington Heights.

In addition, Howard Chodash, MD, immediate-past chairman of the ISMS Resident Physicians Section, was elected vice chairman of the AMA Resident Physician Section. Dr. Chodash is a fellow in gastroenterology at Northwestern University.

Elected in December 1993, Michael Suk, a medical student at the University of Illinois School of Medicine at Rockford, was introduced to the House during the meeting and will fill the medical student trustee position on the AMA Board.

The House of Delegates also elected four trustees to fill open seats on the AMA Board. Percy Wootton, MD, an internist from Virginia, was re-elected. He has served on the Board since 1991. The newly elected trustees are Timothy Flaherty, MD, a Wisconsin radiologist; John Nelson, MD, a Utah obstetrician; and Yank Coble Jr., MD, a Florida endocrinologist.

In addition, Lonnie Bristow, MD, immediate-past AMA Board chairman, started his one-year term as AMA president-elect. He is the first African-American to hold that post. ■

CATAFLAM®

diclofenac potassium
Immediate-Release Tablets

VOLTAREN®

diclofenac sodium
Delayed-Release (enteric-coated) Tablets

Brief Summary (For full Prescribing Information, see Package Insert.)

INDICATIONS AND USAGE

Cataflam Immediate-Release or Voltaren Delayed-Release Tablets are indicated for the acute and chronic treatment of signs and symptoms of rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis. Only Cataflam is indicated for the management of pain and primary dysmenorrhea, when prompt pain relief is desired, because it is formulated to provide earlier plasma concentrations of diclofenac (see CLINICAL PHARMACOLOGY, Pharmacokinetics and Clinical Studies).

CONTRAINDICATIONS

Diclofenac in either formulation, Cataflam or Voltaren, is contraindicated in patients with hypersensitivity to diclofenac. Diclofenac should not be given to patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactoid-like reactions to diclofenac have been reported in such patients.

WARNINGS

Gastrointestinal Effects

Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac even in the absence of previous G.I. tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy: Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous G.I. tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper G.I. ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious G.I. toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious G.I. events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal G.I. events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dose range), sufficient benefit should be anticipated to offset the potential increased risk of G.I. toxicity. **Hepatic Effects:**

As with other NSAIDs, elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [= the Upper Limit of the Normal range]), or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to the enzyme elevations seen in clinical trials, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, have been reported.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Based on this experience, if diclofenac is used chronically, the first transaminase measurement should be made no later than 8 weeks after the start of diclofenac treatment. As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), diclofenac should be discontinued.

To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms), and the appropriate action patients should take if these signs and symptoms appear.

PRECAUTIONS

General

Allergic Reactions: As with other NSAIDs, allergic reactions including anaphylaxis have been reported with diclofenac. Specific allergic manifestations consisting of swelling of eyelids, lips, pharynx, and larynx; urticaria; asthma; and bronchospasm, sometimes with a concomitant fall in blood pressure (severe at times) have been observed in clinical trials and/or the marketing experience with diclofenac. Anaphylaxis has rarely been reported from foreign sources. In U.S. clinical trials with diclofenac in over 6000 patients, 1 case of anaphylaxis was reported. In controlled clinical trials, allergic reactions have been observed at an incidence of 0.5%. These reactions can occur without prior exposure to the drug.

Fluid Retention and Edema: Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac decompensation, hypertension, or other conditions predisposing to fluid retention.

Renal Effects: As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In oral diclofenac studies in animals, some evidence of renal toxicity was noted. Isolated incidents of papillary necrosis were observed in a few animals at high doses (20-120 mg/kg) in several balloon subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during which serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients: creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

Porphyria: The use of diclofenac in patients with hepatic porphyria should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of porphyria. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

Information for Patients

Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, there are more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

Laboratory Tests

Because serious G.I. tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac; these symptoms may become evident between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects).

Drug Interactions

Aspirin: Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

Anticoagulants: While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised, nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

Digoxin, Methotrexate, Cyclosporine: Like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine's nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be monitored.

Lithium: Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

Oral Hypoglycemics: Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experiences of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic effects have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

Diuretics: Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

Other Drugs: In small groups of patients (7-10/interaction study), the concomitant administration of azathioprine, gold, chloroquine, D-penicillamine, prednisolone, doxycycline, or diglofin did not significantly affect the peak levels and AUC values of diclofenac.

Protein Binding

In vitro, diclofenac interferes minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), tolbutamide, prednisolone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlorotetracycline, doxycycline, cephalothin, erythromycin, and sulfamethoxazole have no influence in vitro on the protein binding of diclofenac in human serum.

Drug/Laboratory Test Interactions

Effect on Blood Coagulation: Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII to XII. Statistically significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree; therefore, patients who may be adversely affected by such an action should be carefully observed.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day (or 12 mg/m²/day, approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m²/day) female rats (high-dose females had excessive mortality), but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m²/day) in males and 1 mg/kg/day (3 mg/m²/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in *in vitro* point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was nonmutagenic in several mammalian *in vitro* and *in vivo* tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m²/day) did not affect fertility.

Teratogenic Effects

There are no adequate and well-controlled studies in pregnant women. Diclofenac should be used during pregnancy only if the benefits to the mother justify the potential risk to the fetus.

Pregnancy Category B: Reproduction studies have been performed in mice given diclofenac sodium (up to 20 mg/kg/day or 60 mg/m²/day) and in rats and rabbits given diclofenac sodium (up to 10 mg/kg/day or 30 mg/m²/day for rats, and 80 mg/m²/day for rabbits), and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats.

Labor and Delivery

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during late pregnancy should be avoided and, as with other nonsteroidal anti-inflammatory drugs, it is possible that diclofenac may inhibit uterine contraction.

Nursing Mothers

Diclofenac has been found in the milk of nursing mothers. As with other drugs that are excreted in milk, diclofenac is not recommended for use in nursing women.

Pediatric Use

Safety and effectiveness of diclofenac in children have not been established.

Geriatric Use

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

ADVERSE REACTIONS

Adverse reaction information is derived from blinded, controlled and open-label clinical trials, as well as worldwide marketing experience. In the description below, rates of more common events represent clinical study results; rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In a 6-month, double-blind trial comparing Cataflam Immediate-Release Tablets (N=196) vs. Voltaren Delayed-Release Tablets (N=197) vs. ibuprofen (N=197), adverse reactions were similar in nature and frequency. In 718 patients treated for shorter periods, i.e., 2 weeks or less, with Cataflam Immediate-Release Tablets, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods.

The incidence of common adverse reactions (greater than 1%) is based upon controlled clinical trials in 1543 patients treated up to 13 weeks with Voltaren Delayed-Release Tablets. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or G.I. bleeding occurred in clinical trials in 0.6% (95% confidence interval: 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval: 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%). Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times the ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

Incidence Greater Than 1% - Causal Relationship Probable: (All derived from clinical trials.)

Body as a Whole: Abdominal pain or cramps, headache, fluid retention, abdominal distention.

Digestive: Diarrhea, indigestion, nausea, constipation, flatulence, liver test abnormalities, PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

Nervous System: Dizziness.

Skin and Appendages: Rash, pruritus.

Special Senses: Tinnitus.

*Incidence, 3% to 9% (incidence of unmarked reactions is 1%-3%).

Incidence Less Than 1% - Causal Relationship Probable: (The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Malaise, swelling of lips and tongue, photosensitivity, araphylaxis, anaphylactoid reactions.

Cardiovascular: Hypertension, congestive heart failure.

Digestive: Vomiting, jaundice, melena, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, hepatic necrosis, appetite change, pancreatitis with or without concomitant hepatitis, colitis.

Hemic and Lymphatic: Hemoglobin decrease, leukopenia, thrombocytopenia, hemolytic anemia, aplastic anemia, agranulocytosis, purpura, allergic purpura.

Metabolic and Nutritional Disorders: Azotemia.

Nervous System: Insomnia, drowsiness, depression, diplopia, amnesia, irritability, aseptic meningitis.

Respiratory: Epistaxis, asthma, laryngeal edema.

Skin and Appendages: Alopecia, urticaria, eczema, dermatitis, bullous eruption, erythema multiforme major, angioedema, Stevens-Johnson syndrome.

Special Senses: Blurred vision, taste disorder, reversible hearing loss, scoloma.

Urogenital: Nephrotic syndrome, proteinuria, oliguria, interstitial nephritis, papillary necrosis, acute renal failure.

Incidence Less Than 1% - Causal Relationship Unknown: (Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are italicized.)

Body as a Whole: Chest pain.

Cardiovascular: Palpitations, flushing, tachycardia, premature ventricular contractions, myocardial infarction.

Digestive: Esophageal lesions.

Hemic and Lymphatic: Bruising.

Metabolic and Nutritional Disorders: Hypoglycemia, weight loss.

Nervous System: Parosmia, memory disturbance, nightmares, tremor, tic, abnormal coordination, convulsions, disorientation, psychotic reaction.

Respiratory: Dyspnea, hyperventilation, edema of pharynx.

Skin and Appendages: Excess perspiration, exfoliative dermatitis.

Special Senses: Viscous floaters, night blindness, amblyopia.

Urogenital: Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

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Managed care

(Continued from page 1)

have the attitude, 'If I don't think about it, it will go away.' But the prediction is that by the end of the decade, only 10 to 15 percent of all patients nationally will be fee for service. And even if you're the best doctor in the whole world, there won't be enough of those patients to keep you busy."

ACCESS TO PATIENTS and to managed care networks is a vital concern to specialists, said Stuart Friedman, a manager at the Tiber Group, a Chicago consulting firm that specializes in developing integrated health care systems. "The fundamental component of true managed care is that primary care physicians are functioning as the coordinators of care," Friedman said. Primary care physicians are a necessary resource, since in managed care environments, patient visits to these doctors increase while visits to specialists decrease, he explained. In California, which is second only to Massachusetts in HMO penetration, according to the *Marion Merrell Dow Managed Care Digest*, the successful managed care entities are attracting and retaining primary care physicians. "So you're seeing early retirements of specialists or specialists retraining into primary care. Others are moving to other areas of the country that haven't been hit hard yet with managed care," Friedman said.

Many specialists are also worried about the trend toward capitation and utilization patterns that make primary care

When physicians and managed care collide

Managed care is dramatically impacting physicians and the way they practice medicine. Doctors cannot afford to sit back and avoid making decisions about how their practice will fit in with a fast-changing marketplace, according to health care consultants. Some physicians have already paid a high price for ignoring the presence of managed care entities in their areas, the consultants said.

One eight-physician family practice group experienced a significant loss of patients without warning, said Connie Henderson-Damon, an Oak Park-based consultant. "A major employer in the area changed to a managed care group [to which the physicians didn't belong], and the practice lost 15 percent of its patient base overnight. No one had anticipated the change, and since the practice was geared toward 1,800 visits per month, some employees had to be terminated because there was still the rent and other fixed costs."

In another recent case, a pediatrician discovered that three Ob/Gyns who had always referred patients to him had contracted with three managed care organizations, Henderson-Damon noted. Thereafter, the Ob/Gyns shifted their referrals to physicians in those managed care plans, she said.

"He never was interested in managed care. Until six months ago, he was doing great and thought getting involved in it would squeeze out his fee-for-service patients," Henderson-Damon said. "Now he's in a panic and is on the waiting list of all three of those managed care organizations. As I told him, it's better to have 80 percent of something [managed care patients], than 100 percent of nothing [fee-for-service patients]."

physicians more appealing contractual partners for managed care entities, Henderson-Damon said. She added, however, that a managed care organization may contract with many specialists if they're all considered high-quality physicians. "Cost is a concern for managed care organizations, but these groups don't want underutilization either," she said. "They don't want patients to complain because they're not getting referrals to specialists or because they have to wait a

long time to see someone."

Administration is one area of medical practices that should undergo major revisions, according to several health care consultants. "There is increasing complexity in the business management function of practicing medicine, and there is a changing reimbursement system that's going to impact revenues," Friedman explained. To thrive, physicians will have to become proficient in the business side of their practices as

well as continue to provide quality health care, the consultants said.

"Managed care requires all doctors and practice managers to rethink their business systems," said Karen Zupko, president of Karen Zupko & Associates, a practice management consulting firm in Chicago. "For example, they have to have a system that lets them see if patients are registered so they can verify benefits."

Physicians must also be able to check the specific requirements of each managed care plan to which they belong, Zupko said. "Under the old, regular indemnity system, a primary care doctor might think a patient would benefit from seeing an endocrinologist. He would tell the [employee] at the front desk to make the appointment, the specialist would see the patient and everyone would get paid. Under the new system, doctors have to be more careful about referrals, and the specialists have to know if the plan allows them to accept phone referrals or if they need referrals in writing. If an office doesn't have a good system in place for checking these kinds of things, the doctor is going to be deluged with calls."


Zupko noted that if physicians don't meet a plan's requirements, they probably won't be reimbursed. Therefore, physicians must not let their staff handle such administrative functions unchecked, she said. "Doctors need to make time to meet with practice managers and key office staff to reassess existing business systems. They have to find out whether it is advisable to change the systems, given the kind and number of managed care contracts the practice has signed."

ANALYZING AND SIGNING contracts are essential in joining managed care networks. But the complexity of those contracts can sometimes overwhelm physicians, who may not fully understand the terms of the agreement. "One of the biggest problems is that doctors enter into contracts without doing a review. Those who sign contracts and don't do a critical read of the contract are making a big mistake," Zupko cautioned.

Such omissions can have dire consequences, said ISMS general counsel Saul Morse. He cited the case of a physician who was terminated without cause by a managed care organization that was trying to establish what it called a "balanced network of providers." Although the organization said the termination did not "reflect a negative assessment of [the physician's] clinical confidence," Morse said the physician had no recourse, since the contract specifically stated that either party could terminate the agreement without cause by giving the other party 60-days' notice in writing. "The managed care network didn't violate the terms of its contractual agreement by taking this step, and there is no mention anywhere of the right to appeal this action." Illinois law does not preclude managed care entities from terminating those types of contracts without cause, he added.

"I think most doctors take the approach that if they don't sign a contract, they're automatically out of the plan," said Henderson-Damon. "But that's not necessarily true. They do have some leeway to negotiate. They should at least ask, not assume. And they should never sign a contract before having it legally reviewed." Henderson-Damon noted that physicians should beware of contracts with "incurred but

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Reform

(Continued from page 1)

Committee, also talked about his support for medical IRAs, which he said would "get people involved in the medical marketplace." He said he wants to help Americans understand what is happening in Washington with reform so that they can participate in the process and express their views to legislators. "I don't want to have a bill that has been rejected by the American people to be rewritten in a back room without the full scrutiny of debate."

During a discussion about the U.S. tort system, Wayne Leimbach, MD, an Aurora internist, shared his experience of having been sued for malpractice twice during a two-year period. Although both cases were ultimately dropped, he said he was forced to endure expense, anxiety and stress while the suits were pending.

Dr. Leimbach added that one of his colleagues, a surgeon, has been sued for malpractice six times in cases in which he did not operate on the patient involved. The physician won all six cases, but spent "hundreds of thousands of dollars and months defending himself," Dr. Leimbach said. Those suits have "forever changed the relationship between him and his patients. They have caused him to order more diagnostic tests, which he knew were medically unnecessary, and look upon all patients as potential plaintiffs."

Dr. Leimbach called for a cap on noneconomic damages in medical malpractice suits and accountability for expert witnesses and lawyers who file suits. "Nowhere else in the civilized world can a lawyer file a frivolous suit, lose the suit and walk away without responsibility

for the harm he has done."

Keynote speaker Gail Wilensky, an adviser to President Bush on health and welfare issues and former administrator of the U.S. Health Care Financing Administration, said no bipartisan consensus exists on any federal reform bill. Wilensky said she believes Congress is unlikely to vote on health system reform this year. She added that passing no federal reform legislation this year would be better than enacting bad legislation.

During an afternoon panel discussion, Daniel Hatcher, MD, medical director of the Hillside Living Center, and Dennis Galinsky, MD, director of the DuPage Oncology Center, voiced their concerns

about legislation that could increase hassles for physicians and patients. "I'm worried about the quality of care," Dr. Hatcher said, noting that care will suffer if the government embarks on a "headlong rush with miles of bureaucracy between the patient and service. If the government gets involved, [the system] will get a lot worse."

Dr. Galinsky said he has reservations about the influx of managed care programs. He added that he is also concerned that legislated managed care, such as the system proposed by the Clinton plan, could hinder physicians' ability to treat patients. As an example, he described his attempts to get authoriza-

tion to treat a cancer patient who suffered a collapsed lung on a weekend. The patient's health plan would not give precertification for procedures over the weekend, he said. Although he treated the patient, Dr. Galinsky said the hassle needlessly upset him and his patient.

Another panel member, John Wider, vice president of sales for CIGNA Healthcare of Chicago, said physicians and patients should not fear managed care plans. "All managed care products are different. They are not as draconian as you may be led to believe."

"If I had my druthers, I would keep [reform] in the private sector," Dr. Hatcher said. ■



Dr. Hatcher

Terry Vitacco



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Managed care

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not paid" clauses, which mean the network will pay doctors only if bills are sent to patients within 60 days.

In addition, physicians should scrutinize contracts that contain "hold harmless" clauses, which state that managed care entities can't be sued for any directives given that may have resulted in malpractice suits against member physicians, Henderson-Damon said. "Many malpractice carriers won't cover a doctor who has signed a contract with a hold harmless clause. Before you sign anything, talk with your liability carrier. And be very specific [with the managed care organization] about how you want to change the contract."

Morse stressed that physicians concerned about signing managed care contracts should contact ISMS' new Lawyer Referral Network, a group of more than 60 attorneys with expertise in health care and proven track records of physician advocacy. The attorneys in the network can provide legal assistance regarding managed care arrangements, licensure, contracts, medical staff issues, Medicare and Medicaid, taxation and fraud and abuse. To obtain a referral, physicians may call ISMS' managed care action line at (800) MD-ASIST. ■

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Clearing the hurdle of managed care contracts

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Illinois Medicine

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1994 ISMS legislative highlights

PAGE 2

Doctors and lawmakers focus on health issues

INTERACTION: Female legislators and physicians discuss medical problems afflicting women. By Kathleen Furore

[SPRINGFIELD] Building on existing relationships between doctors and state lawmakers, nine female physicians and 20 legislators attended a dinner in Springfield June 28 to discuss health care issues of special concern to women.

Unlike two similar physician-legislator dinners held in 1993 – at which discussions centered on such controversial issues as expanded functions for nurse practitioners, Medicaid reimbursement, health care reform and birthing centers – this event was structured as an educational forum focusing on the clinical aspects of women's health. The three-hour program covered topics ranging from mammography to migraines.

Physician speakers were Springfield diagnostic radiologist M. Jill Sullivan, MD; Chicago Ob/Gyn Linda Brubaker, MD; Chicago neurolo-

gist and ISMS First Vice President Sandra Olson, MD; Chicago psychiatrist Mary Schaff, MD; and Chicago nephrologist and ISMS Third District trustee Janis Orłowski, MD. Also in attendance were Springfield physicians Jane Jackman, MD, a family practitioner and ISMS Fifth District trustee; Ann Pearson, MD, a pediatrician; Elizabeth Small, MD, a dermatologist; and Elizabeth Strow, MD, a dermatologist. Two senators and 18 representatives also attended.

Dr. Sullivan presented an overview of mammography and its importance in the early detection and treatment of breast cancer. Stressing the excellent survival rate for women whose breast cancer is discovered early, Dr. Sullivan asked legislators to include mammography in the health

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INSIDE

Physicians, city join to fight violence



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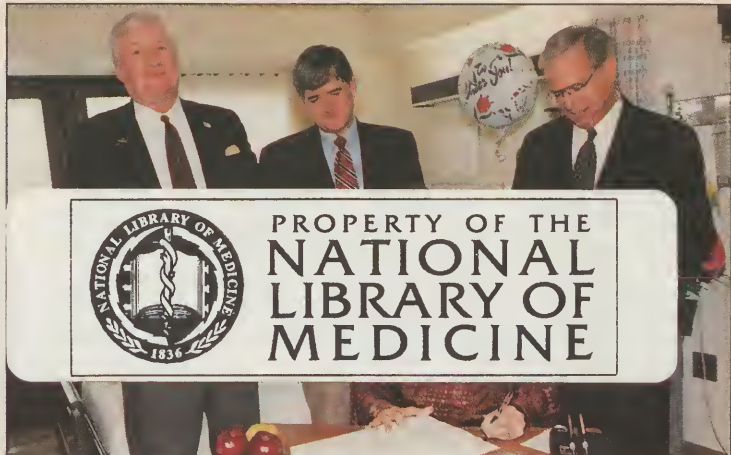
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Matt Ferguson

In his hospital room, Gov. Jim Edgar signs the fiscal 1995 state budget passed by the General Assembly July 12.

Legislature approves budget in overtime

FUNDING: The fiscal '95 budget includes money for old Medicaid bills and public health and mental health programs. By Kathleen Furore

[SPRINGFIELD] It was 12 days overdue. But on July 12, the Illinois General Assembly approved a \$33.37-billion state budget for fiscal 1995 that came within a single percentage point of the budget Gov. Jim Edgar proposed in March. "I am very pleased with the state budget approved today by the General Assembly," Edgar said in a prepared statement released from his hospital room, where he was recuperating from heart-bypass surgery. "Unfortunately, it took a lengthy overtime session to resolve our differences, but I believe this is a good budget. It will not increase taxes."

One of Edgar's highest priorities was identifying funds to pay the more than \$1 billion in delinquent Medicaid bills. According to the governor's office, more than half of those will be paid this year by a \$350-million appropriation, which will be matched by the federal government. In addition, the Medicaid program will

be funded through anticipated downsizing in public aid caseloads and other program cuts, not a restructuring of some of the state's debt, as Edgar initially proposed, said Illinois Department of Public Aid spokesperson Dean Schott. "The Bureau of the Budget, along with IDPA, did a new analysis of expenditures and revenue projections and anticipated fewer [Aid to Families with Dependent Children] and cash assistance caseloads than originally projected," he explained.

The \$5-billion fiscal '95 IDPA Medicaid budget reflects a 21.6-percent increase over 1994 expenditure estimates, according to an ISMS analysis of the state budget. Funding for physician services is \$343 million, a .48-percent decrease from last year's budget, according to the analysis.

In addition to funding for Medicaid, the IDPA budget includes funding for the department

(Continued on page 11)

Market research lays groundwork for positioning medical practices

DEMOGRAPHIC STUDY: Physicians should get to know their patient base to keep patients coming back. By Anna Chapman

[CHICAGO] Physician practices are the only businesses in which the owners don't know their customers, and previously they didn't need to, said Rebecca Anwar, president of Hoover/Anwar Associates Inc., a consulting firm based in Ardmore, Pa. Until now, patients have automatically kept coming back, but that's changing, she noted. The causes of that change are managed care and its effect on the medical marketplace.

To maximize the changing environment, physicians should evaluate their practices if they haven't done so already, consultants advise. Specifically, demographic research can help doctors understand their patient base, market their services, place a value on

MANAGED CARE

their practices, evaluate hospital affiliations, develop referral networks, select sites for office expansion or negotiate provider network agreements, according to Anwar, whose firm specializes in feasibility studies, strategic planning and marketing.

"The point is to get the big picture of what's happening in the practice," said Sandra Gill, president of Physician Management Resources Inc., a consulting firm based in suburban Westmont that specializes in strategic planning and studies of physician-hospital relationships. Physicians should think about revenue and treatment patterns, as well as the clinical treatment of their individ-

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1994 ISMS legislative highlights

All bills passed both the House and the Senate or failed in their house of origin unless otherwise indicated.

BILL	SUMMARY	OUTCOME	ISMS POSITION
S.B. 398	Codifies due process safeguards for evaluating and granting hospital medical staff privileges relative to economic credentialing.	Passed	Support
S.B. 776	Establishes an integrated Medicaid health care system that includes capitated managed care and fee for service.	Passed	Support
S.B. 1154	Sets term limit of four consecutive years for members of the Medical Disciplinary Board. Requires two-year wait before reappointment.	Failed	Oppose
S.B. 1207	Permits optometrists to use therapeutic ocular pharmaceuticals to diagnose and treat.	Failed	Oppose
S.B. 1221	Provides that court-ordered awards to crime victims include payment to providers of products or services, such as medical care providers.	Passed	Support
S.B. 1257, H.B. 3022	Provide for hospital staff privileges for licensed clinical psychologists.	Failed	Oppose
S.B. 1262, H.B. 3013	Enable clinical psychologists to diagnose.	Failed	Oppose
S.B. 1340	Requires pharmacists to dispense generic drugs under certain circumstances regardless of physician direction.	Failed	Oppose
S.B. 1479	Requires health care providers to use uniform claim and billing forms.	Passed	Support
S.B. 1496, H.B. 3277	Impose statutory limits on resident work hours.	Failed	Oppose
S.B. 1499, H.B. 3890	Require creation of a commission to recommend a universal-access health care plan with global budgets and expenditure caps.	Failed	Oppose
S.B. 1505, H.B. 3885	Require direct reimbursement for Medicaid services provided by pediatric or family nurse practitioners.	Failed	Oppose
S.B. 1537, H.B. 2144	Mandate that physicians accept Medicare assignment.	Failed	Oppose
S.B. 1652, H.B. 3406	Establish demonstration program requirements for model birthing centers.	Failed	Oppose
S.B. 1704	Requires a child's parent or guardian to provide a child care facility with either a lead-poisoning risk assessment or a screening statement.	Passed in Senate, failed in House	Support
S.B. 1709	Establishes purchasing pools for employers.	Passed in Senate, held in House	Support
S.B. 1710	Provides credit for losses incurred during pre-existing condition waiting periods.	Passed in Senate, held in House	Support
H.B. 1066	Permits the creation of medical care savings accounts.	Passed	Support
H.B. 2150	Allows 10 new licenses for riverboat gambling. Provides for a \$250,000 cap on noneconomic losses in medical malpractice cases. Amends the Workers' Compensation Act.	Passed in House, Senate deadline extended	Support
H.B. 2635	Authorizes visiting professors to demonstrate or perform certain subjects or techniques.	Passed	Support
H.B. 2695	Makes it a petty offense if a parent stores a firearm and should have known that a minor under 14 could gain access to it and if a minor exhibits the gun without the parent's permission.	Failed	Support
H.B. 3222	Requires insurance coverage for lay midwifery services.	Failed	Oppose
H.B. 3256	Establishes certification for lay midwives through the Illinois Department of Public Health.	Failed	Oppose
H.B. 3383	Provides for a state government-sponsored single-payer health care system.	Failed	Oppose
H.B. 3499	Bans smoking in restaurants.	Failed	Support
H.B. 3737	Exempts health care providers from civil damages resulting from acts or omissions regarding free treatment of indigent patients referred from a free clinic.	Failed	Support
H.B. 3911	Establishes tattoo artist licensure to be administered by the Illinois Department of Professional Regulation.	Passed in House, held in Senate	Support
H.B. 4050 H.B. 4189	Establish utilization review protections for patients, hospitals and physicians.	Failed	Support
H.B. 4192	Protects health care providers from liability for certain claims if they rely on direction from a patient's guardian.	Failed	Support

Study looks at kids' access to cigarettes

SMOKING: Education helps curb tobacco sales to minors.

By Kathleen Furore

[CHICAGO] A pilot study by DePaul University and the Chicago Department of Revenue found that 87 percent of the 120 Chicago businesses it monitored sold cigarettes consistently to teen-age customers. According to the study results, the 16- and 17-year-olds who tried to buy cigarettes from selected convenience stores, gas stations, pharmacies and grocery stores were usually successful during their four trips to the retail operations.

Following the investigations, store managers were given educational packets outlining the city's ordinance prohibiting tobacco sales to minors, a sign notifying patrons of age requirements to buy cigarettes, instructions about checking IDs and warnings that \$200 fines would be issued for future violations. After those efforts, 63 percent of the stores sold cigarettes to kids. And although the rate soared to 88 percent two months after the warning, it dipped to 50 percent when investigators cited stores that continued to sell tobacco products to minors.

"This is a perfect example of what behavioral community psychology is all about - solving problems," said Leonard Jason, a DePaul psychology professor who coordinated the study. He noted, however, that study results indicate the need for continued enforcement to maintain compliance.

According to DePaul, the study is ongoing and compliance checks are continuing so that researchers can determine how often they're needed to maintain effective enforcement. And Chicago Department of Revenue Director Judith Rice warned that revenue inspectors will enforce the law against all merchants in Chicago, not just those in the study. "We take the issue of underage smoking very seriously and will do all we can to battle this national epidemic," Rice said.

Physicians are also concerned about teen-age smoking. During its 1994 Annual Meeting, the ISMS House of Delegates adopted policy supporting legislation that prohibits minors from possessing tobacco.

Chicago Alderman Edward M. Burke, who sponsored legislation transferring primary enforcement of the city ordinance from the police to the revenue department, said, "Most smokers became addicted to cigarettes as teen-agers, and by strictly enforcing the city's law against selling tobacco to minors, we hope to prevent kids from becoming hooked before they're old enough to know better." ■

HCFA survey evaluates Medicare carrier performance

To help improve the quality of service to physicians who treat Medicare patients, the U.S. Health Care Financing Administration has selected 500 physicians in each Medicare carrier's service area to participate in a survey designed to evaluate their satisfaction with their carriers' performance. The nationwide survey, begun in early July, is an expanded version of a successful 1993 pilot survey of five regional car-

riers, according to HCFA.

The survey will help HCFA and its Medicare carriers identify strengths and weaknesses and ultimately help carriers improve service to physicians, HCFA said. Areas addressed are claims processing, telephone service, written inquiries, outreach activities and the appeals process. HCFA also noted the survey and process for reviewing responses have been

designed to ensure confidentiality: No physician-identifying information is requested on the form, and Medicare carriers will not be told which physicians participated in the survey. Participation is voluntary for the 500 physicians, and HCFA said completing the survey should take just 15 minutes.

For more information, physicians may call Rayna Thormann at (410) 966-0537 or David Boyd at (410) 966-5749. ■

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REPORT

FOR *Illinois Physicians*

APPROPRIATENESS REVIEWS

For sometime, managed care organizations have utilized "appropriateness reviews" as a methodology for enhancing quality of care by reducing the incidence of medically unnecessary or inappropriate services. In general, appropriateness reviews are applied to high frequency procedures, high cost procedures, and to procedures in which there is a high degree of medical discretion, i.e., procedures for which the indications may not be accepted by all physicians. Furthermore, the elimination of medically unnecessary services is by definition a legitimate mechanism for improving utilization levels and properly controlling costs.

In view of the usefulness of appropriateness reviews, Blue Cross Blue Shield of Illinois (BCBSI), has decided to introduce such reviews at this time in one of BCBSI's small managed care products, Managed Care Network Preferred (MCNP), which is a so-called "point-of-service" product in which a very high level of benefits is applied to care provided by or authorized by a designated primary care physician, but in which the level of coverage is greatly reduced for non-authorized or out-of-network care. In fact, precertification of certain non-emergent services has been required in MCNP since January 1, 1994, but beginning on June 27, 1994, physicians will be asked to provide MCNP with some relevant clinical information which will be used to evaluate the appropriateness of a limited number of non-emergent procedures. The clinical criteria that will be used have been promulgated by a well established national company which convened panels of expert physicians who actually developed the criteria. The procedures must always be approved by the primary care physician. Physicians who participate in MCNP have been notified by letter of the process they are to follow to obtain precertification for these procedures. The procedures must always be approved by the primary care physician. All cases of possible denials will be scrutinized by a BCBSI physician advisor, who will generally call the attending physician to directly discuss the indications for the procedure, before a decision is made. Attending physicians may also ask for an appeal process through a review by a different physician advisor.

The procedures for which clinical information will currently be required are:

- CT/MRI of the Brain
- Pelvic Laparoscopy
- Hysterectomy
- PTCA
- Lumbar CT/MRI/Myelography
- Repeat Cesarean Section
- Laminectomy/Disc Excision/Fusion
- Arthroscopy of the Knee
- Hip Arthroplasty
- Surgery for Breast Cancer
- Cholecystectomy

Additional procedures may be added to the above list in the future; if so, MCNP physicians will be notified of this by letter. If appropriateness reviews are introduced into other BCBSI product lines, the physicians who participate in that specific network, will again be notified by letter.

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Physicians, city join to fight violence

ACTIVISM: Aurora pediatricians and trauma surgeons work to create programs to link victims with community services. By Anna Chapman

[AURORA] As community violence spreads beyond the Chicago metropolitan area, some physicians and public officials are beginning to take action. In Aurora, pediatrician Julie Overcash, MD, and other local physicians testified before the city council in May in support of a resolution to ban assault weapons.

The ordinance, introduced by Aurora Mayor David Pierce, eventually passed.

It bans certain semiautomatic military-style rifles, pistols and shotguns that fire large amounts of ammunition or have other potentially lethal features such as telescopic viewfinders and silencers, according to Aurora police Lt. Michael Gillofio. Citizens may keep semiautomatic weapons not covered by the ban, such as guns used for target shooting, but those individuals must obtain a cer-

tificate of ownership by September, Gillofio said.

"I'm not going to say the ordinance will reduce violence, but it is a proactive step to curb an increase in violence," Pierce noted.

The ordinance has received extensive support from physicians. Numerous articles have been published in the local newspaper on violence in the area, including one on how families cope with gangs. Ninety-five area physicians signed a letter to the editor supporting the ban on assault weapons. "We urge the city council to place restrictions on the possession of firearms by minors," the physicians wrote. "Penalties for violation of these restrictions should be strict and imposed on the minors and their parents. We understand that these programs will not solve all problems of violence, but we feel these measures are an important step forward."

Pierce described Aurora as a city of 100,000 people, with a large minority and low-income population. "We're all seeing an upsurge in violence — Rockford, Joliet. Too many kids are resorting to guns to solve their problems. And this can't be solved in the schools alone. The goal is to find a way to identify perpetrators of violence. Of course, they end up in the hospitals as violence victims."

During well-baby checks, Dr. Overcash asks parents about guns in the household, she said. "If children are older, I ask if they have any questions about violence and whether they or other family members are involved. Violence affects the whole family."

During national "Let's Stop Kids Killing Kids Week" in late April, physicians and staff from Mercy Center for Health Care Services joined city officials, including Pierce, in a roundtable discussion on providing services to victims.

"The discussion was a dialogue that

gave health care workers the opportunity to have direct input on a social problem relevant to us all," said Nancy Hopp, spokesperson for Mercy.

The information exchange allowed physicians to learn about the resources for curbing violence, and the physicians described the problem as they see it in the hospital, said Dr. Overcash. "The city took a week and made a concerted effort against firearms."

"The pediatricians and the surgeons on the medical staff are most directly involved in care of victims of violence," said Kim Reed, MD, vice president of medical affairs at Mercy. "The pediatricians expressed concern and wanted to get involved even before the forum. They were interested in creating programs on violence."

Because victims of crime are also often perpetrators, health care professionals may have an opportunity to intervene and prevent future violence when they treat victims in the hospital, Pierce said. Pierce and physicians at the hospital plan to follow up this fall by developing a program that would allow health care workers to link violence victims with community services.

"The program is not yet defined, but we know that drug addicts and alcoholics often seek help only when they have reached bottom. It may be the same with those who commit violence," Pierce explained. "When they are victims in the hospital, they could say, 'I made it this time. I'm not dead. But I could get killed.'"

ISMS policy endorses legislative and educational efforts such as these. Specifically, the Society supports the right of counties and municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. In addition, the House of Delegates directed ISMS to encourage education programs about the dangers of firearms and to prompt gun control legislation in the General Assembly calling for owner liability, buy-back programs, locked gun storage in homes and more-restrictive handgun licensing. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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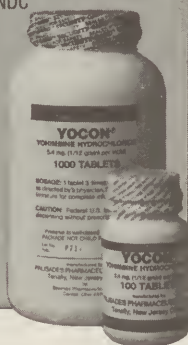
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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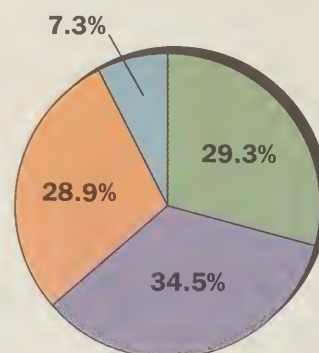
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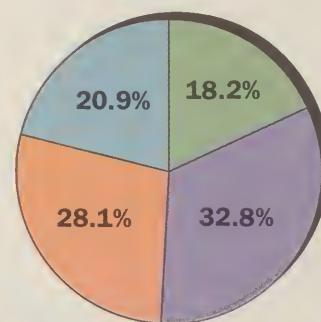
PHYSICIAN FACTS

How the threat of liability influences decisions made by physicians

Influence on ordering of tests and procedures



Influence on making referrals



Major influence
Minor influence

Some influence
No influence

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Illinois physicians receive AMA recruiting awards

[CHICAGO] Fifteen Illinois physicians garnered 1994 AMA Physician Outreach program awards during the AMA's Annual Meeting in June. The awards are presented annually to physicians who recruit nonmember colleagues to join the AMA. Since Illinois is a unified state, all physicians who join the AMA also become members of ISMS and their county medical society.

"The AMA Outreach programs are a critical part of our overall recruitment efforts because of their unique person-

to-person approach," said Marsha Turner, assistant director of the AMA's Outreach programs.

Four groups of physicians participate in the recruitment programs: the AMA's House of Delegates, its Hospital Medical Staff Section, its Young Physicians Section and its Medical Student Section. Another program, On Call: Member-Get-a-Member, is for AMA members who don't participate in leadership groups, Turner explained. Through the programs, prospective recruiters accu-

mulate points for each new member they recruit for full-year dues.

Illinois' top recruiters in the House of Delegates Outreach program were ISMS First District trustee Albino Bismonte Jr., MD, of Gurnee; Silvana Menendez, MD, of Belleville; and ISMS Board Chairman Ronald G. Welch, MD, of Belleville. Leading the Hospital Medical Staff Section Outreach program's list of award winners were Joseph L. Murphy, MD, and Maynard Shapiro, MD, both of Chicago. All were recognized for recruit-

ing more than seven new members annually for at least three consecutive years.

Other Illinois award winners in the House of Delegates program were William J. Marshall, MD, of Olympia Fields, and Arthur Traugott, MD, of Urbana. Additional HMSS winners were Donald Buser, MD, of Belleville; Charles Drucek III, MD, of Evanston; Donald Edwards, MD, of Dixon; Wilfredo Granada, MD, of Zion; Richard Schmidt, MD, of Ottawa; Shastri Swaminathan, MD, of Chicago; and Gail Williamson, MD, of Chicago. Arden Barnett, MD, of Naperville, was recognized in the Young Physicians Section program. ■

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

Voters speak out on reform and physicians

Our efforts to inform the public about health care reform and caps on noneconomic damages in malpractice cases are hitting home. Eighty-two percent of Illinois voters would rather pay more for health care and have physicians set practice guidelines than pay less and have insurers establish guidelines. That was just one of several encouraging results of a recent ISMS poll.

Other findings were equally supportive. Sixty-four percent agreed with the following statement: "The debate over health care reform shows the system is too complex to be reformed this year, and Congress should proceed more slowly." On the other hand, only 28 percent agreed with this statement: "Congress is making progress in the debate over health care reform and should focus all its efforts on passing a bill before the end of the year."

And the good news on tort reform is that 72 percent recognize how malpractice lawsuits impact health care costs, and they support limits on noneconomic losses in such suits. Only 21 percent of those surveyed oppose limits. We're definitely making progress on this issue. In a 1989 ISMS survey, only 62 percent supported caps, and 32 percent opposed them.

The Illinois voters polled expressed satisfaction with the health services they receive but concern about the cost of care and health insurance. Specifically,

eight of 10 respondents are happy with the availability of health care services, the quality of health care, the amount of time they have to wait before seeing a doctor and the ability to go to a specialist. Eighty-nine percent said they are satisfied with their relationship with their physician. However, 55 percent indicated dissatisfaction with the costs of health care and health insurance.

Apparently Illinois voters don't like the Clinton reform plan much more than physicians do. More respondents oppose the plan than those who favor it. And more said a plan agreed on by Clinton and Congress would change health care for the worse than those who indicated the plan would improve health care.

Physicians also rated high marks as credible sources of information regarding health care reform. On a scale of zero to 10, "your doctor" scored an average of 7.91, outdistancing the other 10 choices.

This survey shows that Illinois voters are getting the message about the dangers of the Clinton plan, the need for deliberate health care reform and the impact of malpractice lawsuits on health care costs. It also demonstrates our patients' trust in us and the value they place on our relationship. Let's make it a priority to continue our patient advocacy and keep talking to our patients about the health care reform that's best for them.

PRESIDENT'S LETTER

Of sunsets and footprints in the sand

Alan M. Roman, MD



Summer vacation is when midafternoon catnaps in the hammock are no longer considered a compromise of the work ethic.

This is the time of year I like best. If I tell you why, I know you'll smile and nod your head: warm, golden sand beaches; cool, gentle lake breezes; the view, from the back deck, of brightly colored nylon sails; the smell of ribs and chicken on the barbecue mixed with the scent of cocoa butter. No late-night pizza this week. No call. No responsibility. Summer vacation is days off, a wonderful brain-break and life the way it should be.

The road to success for ISMS has been uphill and downhill, challenging and rewarding. We've made a lot of progress this year on practice guidelines, health system reform and peer-based quality-assurance review in the new Medicaid legislation. These gains have resulted from your dedication, energies and commitment.

Today, though, is the time for a pleasant detour. Hard work should not be without its rewards. Getting away from it all mentally and physically allows us to recharge our batteries and feel better about ourselves physically, emotionally and spiritually. Vacation is a time to get in touch with who we are, reflect on our past and plan for our future and our true priorities.

Summer vacation is when midafternoon catnaps in the hammock are no longer considered a compromise of the work ethic, and when sand castles, ice cream cones and sprints across the hot sand into cool Lake Michigan waters bring childhood (which was too short) back into our grasp. But mostly it is a respite from being wired and tired and a chance to give our dreams the license to happen.

For me, Michigan's harbor country is all this and more. There, the grass is always greenest and life in the slow lane allows me to share feelings and time with loved ones and friends. It is a place of rest and relaxation where I can be less than perfect. It is a simple

setting, one in which everything doesn't have to be analyzed. I can let go of things I can't control and even laugh a lot. And I can count my blessings and note the good things that have happened to me and mine.

How I look forward to and profoundly enjoy barefoot beach days, sparkling blue waters, kite-flying with the children and sailing with my wife. And I can't forget my favorites – supper on the beach at sunset, followed by long walks along the shore, with the cool sand between my toes, and then late-night reading on the porch. These are ample rewards for some of the self-sacrifice of the profession, as well as reminders to make enjoyment of life one of the year's highest priorities.

Summer vacation, you see, is an opportunity to be your own best friend, free from self-criticism and judgment. It is a time to forgive yourself and energize yourself to accomplish what you need to do in order to feel your life is complete.

Today is fleeting and easily forgotten. Tomorrow comes too quickly. Too soon, Labor Day will come and, with it, renewed energy to pursue the Society's agendas – health system reform, fall elections, the President's Tour and tort reform. This fall, more than ever before, I will ask for your enthusiasm, your strength and your skills. Your talents, individually and collectively, will provide the essential elements necessary to build on our strong foundation for a stable future.

But for the moment, relax, regroup and refresh, whether you go to a beachside bungalow or anywhere that phone service can't reach. Although vacation is but a short parenthesis in a long period, it is a moment in time that creates memories to be cherished forever. And there are few things that sunsets and footprints in the sand won't heal.



"I'm warning you, you've got to slow down."

GUEST EDITORIAL

Unhealthy maintenance organizations

By Kip Sullivan and Keith W. Sehnert

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Few states have a higher percentage of their citizens enrolled in health maintenance organizations than Minnesota. For that reason, Hillary Rodham Clinton and other advocates of managed competition cite Minnesota's health care system as a model. The two of us think our system is a warning, not an example.

There is no conclusive evidence that Minnesota's HMOs have reduced health care costs. (There is debate over whether the costs have increased.) But there is abundant evidence that in a state dominated by large HMOs, doctors have less time to see patients, doctor-patient relationships are more vulnerable to disruption and doctors and patients have lost substantial control over decisions affecting patients' health.

Since 1975, HMOs – the cornerstone of managed competition – have acquired such market power through growth and mergers that competition in the health-plan industry in the Minneapolis-St. Paul area has been crippled. And since 1982, to create countervailing power, nearly all of the area's 24 independent hospitals have formed three chains, thereby destroying what little competition had existed among the hospitals.

Today, the HealthPartners and Medica HMOs and Blue Cross/Blue Shield (a managed care company) enroll half the state's 4.4 million people. And the hospital chains control about 60 percent of the Twin Cities market. (Many economists argue that when four companies control more than 40 percent of a market, competition is damaged.)

Neither of us opposes small, locally controlled HMOs. We both oppose what Minnesota's HMOs have become. As the HMOs grew in size and income, exorbitantly paid executives and man-

agement companies – oriented to revenue, not service – took them over.

In the late 1980s, the three hospital chains began aggressively buying up physicians' practices. When doctors go to work for hospitals, they and their patients inevitably cede some authority over decision-making to hospital management.

A year ago, the state enacted a managed competition law, which encouraged the HMOs and Blue Cross to merge or sign agreements with some of the remaining independent hospitals and two of the hospital chains. They have signed agreements with clinics and networks of doctors throughout the state as well.

Rural hospitals and clinics have responded by initiating or accelerating efforts to organize provider networks. One of the largest is the network developed by the Mayo Clinic, in Rochester, Minn. Most of the rural networks will ultimately ally with one of the HMOs, Blue Cross or a hospital chain. If that happens, most rural Minnesotans will buy care from monopolies with ties to a sugar daddy in the Twin Cities.

Many doctors, especially those in rural areas, feel that their independence and relations with patients are threatened by the consolidations. That hostility found an outlet at the convention of the Minnesota Medical Association in October. A resolution to endorse a single-payer pilot program failed, but by a narrow 86-80 vote.

The two HMOs and Blue Cross have warped the health care reform debate in Minnesota. They persuaded the Department of Human Services to suppress a study that concluded that Minnesota's HMOs do not serve poor women well. They kept two state commissions from studying a single-payer system. They helped kill a bill to cut drug prices for consumers – a bill that pharmacists had endorsed.

Is this the system Hillary Rodham Clinton wants the nation to have?

GUEST EDITORIAL

Health care: From topic A to Zzzzzzz

By Dave Barry

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Today I want to bring you up to date on national health care. I happen to know quite a bit about this because I had lunch recently with Hillary Rodham Clinton, although she was probably unaware of this fact because the room also contained several thousand newspaper executives belonging to the Newspaper Association of America (motto: "Keeping You Accurately formeblksdfxc"). It was one of those mass banquet luncheons where squadrons of waiters come swooping out of the kitchen carrying trays stacked high with plates protected by steel covers, which they whisk off at your table to reveal, to your astonishment and delight: chicken.

The reason you always get chicken at these affairs is the Federal Interstate Chicken Transport System (FICTS), which was built during the Eisenhower administration to ensure that the nation would still be able to hold its banquet luncheons after a nuclear war. All major hotels are connected via a vast underground network of pneumatic tubes to huge chicken factories in Delaware and Arkansas, where thousands of chicken parts per second (c.p.p.s.) are fed into the tubes under extremely high pressure. These parts sometimes travel thousands of miles before blasting out into hotel kitchens all over the nation, where workers frantically convert them into banquet meals to make room for new incoming chicken, which arrives constantly. (There is no way to stop it; this is a federal program.) Each year hundreds of kitchen workers are injured by chicken breasts traveling at upwards of 400 m.p.h. This is yet another reason why we need to be concerned about health care.

So I was eager to hear Mrs. Clinton's speech before the American Newspaper Association luncheon. It was great. She kept the crowd in stitches with a series of hilarious health care jokes, such as the one about the guy who goes to see the doctor because he keeps finding turtles in his undershorts.

No, I am kidding. Mrs. Clinton did not tell jokes. I have heard funeral speeches with a higher humor content. Mrs. Clinton is VERY serious about health care. She knows TONS of facts about it. I can tell she's the kind of person who, in 6th grade, had her Science Fair project done early, and it featured elaborate, neatly lettered color diagrams and a meticulously executed experiment involving test tubes and petri dishes, clearly demonstrating some complex scientific thing involving enzymes; whereas people like me showed up with last-minute projects featuring Dixie cups and a hastily scribbled cardboard sign with a title like "THREE KINDS OF DIRT."

So I tried to pay close attention as Mrs. Clinton discussed the administra-

tion's health care plan. I would say she's in favor of it. I'm afraid I can't offer much more detail because health care is one of those issues – another is the bond market – that my brain refuses to think about.

"PAY ATTENTION!" I'd tell my brain. "The First Lady is explaining health care!" But my brain would drift off, pursuing its own interests, trying to remember the words to the Beach Boys' 1963 song, "Our Car Club," which never gets played on the radio, and for good reason. Mrs. Clinton would be talking about the administrative expenses of Medicare, and my brain would be singing:

"We'll have the roughest and the toughest initiation we can find. ..."

Then Mrs. Clinton would be talking about the inequities of drug pricing, and my brain would be singing:

"And if you wanna be a member, we'll really put you through the grind!"

It's a good thing I'm not in charge of national health care. I can't understand my own medical bills. Last spring my son suffered some injuries requiring medical treatment, and ever since, I've been receiving incomprehensible bills from dozens of random medical computers. I'm pretty sure that I'm now paying for medical care given to people injured in the Hindenburg disaster. There's no way to tell because the bills all look like this:

"With reference to the above referenced account, your 73 percent deductible differential has not been satisfied with respect to your accrual parameter, and therefore you are obligated to remit \$357.16 no make that \$521.67 here are some more random amounts \$756.12, \$726.56 and \$3,928,958.12 bear in mind that we would enjoy nothing more than seeing your pale skinny body in prison."

This is a true story: Awhile back, out of the blue, I started receiving threatening letters from a collection agency representing a hospital, demanding \$101.76. So I sent the agency a check.

Last week, on the SAME DAY, I received (a) a letter from the collection agency returning my check, with a note stating that I did not owe the money; and (b) a NEW threatening letter from the same agency, demanding \$101.76. I'm thinking that the only way out of this might be the Federal Witness Protection Program.

Of course, I'm sure medical care will become much simpler and more efficient once it's being handled by the federal government (motto: "We Are Not Authorized To Tell You Our Motto"). I'm hoping that Mrs. Clinton and the Congress work out some kind of plan soon, and I'm hoping that it covers routine doctor visits. Because I need to see somebody about these turtles.

Physicians
should
consider
liability
issues when
reviewing
managed care
contracts

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ISMIE Update

Survey shows
Illinois voters
support tort
reform

PAGE 6

There's more to insurance ratings than meets the eye

Companies that rank insurers have different policies and research methods.

By Kathleen Furore

[CHICAGO] How important are insurance ratings for medical malpractice insurers? The answer would be "very important" if such ratings always indicated a company's financial strength and availability to policyholders, said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. But that is not always the case, Dr. Jensen said, adding that insurance companies that receive low or no ratings may be perfectly sound, while those with A ratings could fail.

"The rating process is complex, and it's important to examine the various procedures used by different companies that issue ratings," Dr. Jensen noted. "Ratings can be confusing and misleading, since at times, the methodologies these companies use to assign the ratings are unclear or questionable."

For example, Weiss Research, a Florida company that began rating the country's property-casualty insurance companies

last year, gave ISMIE a safety rating of D. But Weiss has a controversial track record at best, according to an August 1993 report in the *National Underwriter*, a prominent publication covering property-casualty insurance issues.

The article points out that unlike other rating companies that rely on a staff of sophisticated actuarial professionals, Weiss has only one in-house actuary and several data researchers who use data tapes, company reports, records from the National Association of Insurance Commissioners and a proprietary computer program to determine its safety ratings.

"Weiss uses published financial data and puts them into a computer model. The company doesn't talk to management [as other rating companies do]. It just looks at numbers, not at what's underlying those numbers," said an ISMIE analyst.

The controversial nature of the Weiss ratings is evidenced by

the fact that many large insurers labeled weak by Weiss earned top grades from A.M. Best — a ratings firm considered very reputable in the insurance industry, according to Manuel Almagro, a consulting actuary for Tillinghast, an actuarial and risk management consulting firm in Westport, Conn.

As the *National Underwriter* story noted, Weiss slapped D ratings on U.S. Fire Insurance, the Insurance Co. of North America and the Industrial Indemnity Co. of California, and a D+ on Aetna Casualty and Surety — even though those insurers garnered an A or A- from Best.

"I don't know if I can say exactly why our ratings differ [from those of other rating companies]," said Weiss spokesperson Greg Dubois. "I can tell you we are very conservative and look at things from a very qualitative stance. Some companies use a mix of qualitative and quantitative analyses. They do

number crunching and then consider things management says [to explain the numbers]."

By comparison, A.M. Best bases its ratings on quantitative evaluations that include an extensive analysis of an insurer's financial performance in areas like profitability, leverage and liquidity, and qualitative evaluations that encompass such factors as the company's spread of risk, the quality of its assets, the adequacy of its reserves, reinsurance protection and management competency. Consequently, the Best ratings represent a total risk profile, according to an article in the July/August 1993 issue of *Contingencies*. This means insurers won't be rated poorly simply because one component is unacceptable — as long as their overall score indicates financial strength, the article states.

There are, however, circumstances that make it difficult for insurers to receive a letter rating from Best — even if those companies are financially stable and have the profitability and leverage ratios to prove it. ISMIE fits into that category.

ISMIE received a 1993 Best rating of NA-6, because the company is reinsured by several international companies that are not rated by Best, Dr. Jensen said. This rating is explained in the

write-up of ISMIE in the 1993 edition of *Best's Insurance Reports*, which says: "A significant portion of policyholders' surplus is represented by reinsurance recoverables due from unrated reinsurers, and consequently our rating procedure does not apply."

The Best report also states that ISMIE is the "largest writer of medical professional liability in the state of Illinois and ranks among the five largest writers of professional liability in the United States." In addition, Best cites ISMIE's "sound liquidity position."

According to Rhonda Ruch, a Best spokesperson, the company rates more than 99 percent of domestic insurance companies but has not been active in the international insurance community. "We've just started to deal with international companies in more depth over the last four to five years," Ruch said, adding that as Best expands into the international insurance marketplace, it will be able to increase the number of insurers and reinsurers it rates.

ISMIE's relationship with European and London-based reinsurers is the sole reason for its NA-6 rating from Best, an ISMIE analyst explained. "Best uses year-end financial state-

(Continued on page 9)

MALPRACTICE ROUNDUP

Internist can testify regarding gastroenterologist's standard of care

The Virginia Supreme Court recently ruled that an internist was qualified to testify about whether a gastroenterologist met the standard of care for reviewing medical records, according to a case summary in *Medical Malpractice Law & Strategy*.

In *Griffett vs. Ryan*, the patient presented at the emergency room with a complaint of abdominal pain. A radiologist reviewed X-rays ordered by the ER staff and noted an abnormal density in the patient's chest. Subsequently, the patient was referred to the defendant gastroenterologist, who examined and discharged him without reviewing the radiologist's report or the chest X-ray. Two years later, the patient learned that the abnormal density seen in the initial X-ray was a cancerous tumor, which had quadrupled in size since the first X-ray was taken.

During the resulting trial, an internist called as the plaintiff's expert witness testified that the gastroenterologist had not complied with the applicable standard of care because he failed to review the initial radiology report and the chest X-ray. However, the defendant argued that the internist was not qualified to render opinions about the standard of care for a gastroenterologist. The trial court allowed the internist to testify and ruled in favor of the plaintiff but later reversed its original decision to allow the testimony and set aside a verdict for the plaintiff. The court entered final judgment in favor of the gastroenterologist.

The case was ultimately decided by the Virginia Supreme Court, which ruled that the standard of care regarding basic review of a patient's medical records should not vary between an internist and gastroenterologist. The court noted that a gastroenterologist is an internist with a subspecialization in gastroenterology. The court also acknowledged that there may be some instances in which an internist would not be qualified to assess the standard of care provided by a gastroenterologist, but it said this was not such a case. ■

AIDS test performed without consent

A patient who accused a Skokie physician of performing an AIDS test without consent will receive \$10,000 from the physician to settle the federal lawsuit filed as a result of the test. The patient went to see the physician in 1992 complaining of jaw and ear pain, according to a July 1 story in the *Chicago Sun-Times*. During the exam, the physician asked the patient if he was or ever had been married, the story said. When the patient said he was gay, the physician allegedly told him he would contract AIDS.

The physician took blood samples to measure kidney function, a test for which the patient gave consent, since he'd had a kidney transplant in 1987.

The patient filed the lawsuit after learning that the physician reportedly also had the blood tested for the AIDS virus, the article said. ■

ISMIE responds to risk management article

The following letter to the editor was written by Chairman of the ISMIE Board of Governors Harold L. Jensen, MD, in response to an article published in *Hospital Risk Management*:

As chairman of the board of the Illinois State Medical Inter-Insurance Exchange, I take issue with the article (May 1994) titled "Check out physicians' insurance carriers before granting privileges." The article refers to Weiss Research and the "low grades" given to ISMIE by the research firm. The article also points out that of 93 companies specializing in medical malpractice, 42 percent are rated weak by Weiss, while 17 percent are rated good.

Unfortunately, the article makes no mention of the criteria and considerations on which Weiss bases its ratings. Weiss began rating property-casualty insurers just last year. Unlike other well-known and credible rating companies such as Standard & Poor's and A.M. Best, which use a balanced quantitative and qualitative approach, Weiss uses only published financial data and puts them into a computer model. This approach appears to result in a marked difference between Weiss ratings and those of these venerable rating firms. For example, while prominent insurers such as Aetna Casualty and Surety and Industrial Indemnity Co. of California have been awarded D or D+ ratings from Weiss, these same companies received A-range ratings from A.M. Best and Standard & Poor's.

In the Aug. 30, 1993, issue of *National Underwriter*, a nationally recognized insurance industry publication, in an article titled "Weiss begins rating property-casualty insurers," Warren Levy, an assistant vice president with Cigna (parent company of Insurance Co. of North America), said, "The secrecy that surrounds the development of the Weiss product makes it a pig-in-a-poke rating as far as anyone being able to look at it and say, 'This is what it says about a company.'"

We have yet to hear from Weiss as to exactly what shaped its rating of ISMIE. As officers of an insurance company, we know that ratings of any kind are only one factor and do not necessarily indicate the financial strength and integrity of a company to its policyholders. For example, ISMIE is the longest continuous provider of medical professional liability insurance in Illinois, meeting the needs of its policyholders for 19 years, while many other insurers have come and gone. In addition, ISMIE has consistently passed numerous NAIC tests of financial security and continues to meet the strict regulatory standards of the Illinois Department of Insurance.

When ratings are considered as part of an insurance company evaluation, it is critical to understand the methodology behind them. ■

Insurance ratings

(Continued from page 8)

ments as the basis for its ratings, and although these statements are uniform throughout the United States, they differ widely from country to country. Each of our reinsurers has a long history of solvency. In addition, most have received good ratings from Standard & Poor's, which also rates insurance companies."

Dr. Jensen added that ISMIE regulators work continually to monitor the solvency of its reinsurers and the availability of benefits to its policyholders. "It's nice to have a third-party endorsement, such as a good letter rating from a reputable com-

pany like Best, but it's no guarantee a company will stay in the market. We'll be here for Illinois physicians, even if everyone else leaves the market."

In addition, ISMIE has passed NAIC tests designed to measure insurers' financial security. The tests are actually financial ratios prepared using information gleaned from the NAIC's data base of insurers' financial statements and are analyzed by experienced financial examiners, said an NAIC spokesperson. This financial analysis system – called the Insurance Regulatory Information System – calculates company ratios based on annual statements and compares those ratios to a "usual range" of ratio

results. Usual results are based on ratio studies for companies that recently failed or that experienced financial difficulty, according to the NAIC.

"ISMIE has always performed well in the NAIC analysis," Dr. Jensen said. "The company undergoes an outside audit by Ernst & Young each year, and the financial records are assessed by independent actuaries on a consulting basis. The Illinois Department of Insurance also closely reviews the company every three years. We pride ourselves on being the Physician-First Service insurer, but our main responsibility is keeping the company financially sound." ■

Seizures controlled, thoughts clear, smiles bright

IN THE CLASSROOM...



Low risk of cognitive impairment¹

Generally avoids hirsutism^{2,3}

Avoids gingival hyperplasia^{2,3}

IN THE BOARDROOM



Tegretol 
carbamazepine USP

...because after seizure control, there's a lot of living to do!

200-mg scored tablets
100-mg chewable tablets
Suspension, 100 mg/5 ml

ciba

Tegretol is indicated as first-line monotherapy for children 6 years of age or older and adults. The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea, and vomiting. To minimize the possibility of such reactions, therapy should be initiated at the lowest possible dose. As with all anticonvulsant therapy, periodic hematologic evaluations are recommended at the physician's discretion. Although reports of transient or persistent decreased platelet or white blood cell counts are not uncommon in association with the use of Tegretol, the vast majority of cases of leukopenia have not progressed to the more serious conditions of aplastic anemia or agranulocytosis.

Please see complete Prescribing Information and references on next pages.

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References:

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- Mattson RH, Cramer JA, Collins JF, et al. Comparison of carbamazepine, phenobarbital, phenytoin, and primidone in partial and secondarily generalized tonic-clonic seizures. *N Engl J Med*. 1985;313:145-151.
- Herranz JL, Armijo JA, Artega R. Clinical side effects of phenobarbital, primidone, phenytoin, carbamazepine, and valproate during monotherapy in children. *Epilepsia*. 1988;29:794-804.

Tegretol®

carbamazepine USP

Chewable Tablets of 100 mg - red-speckled, pink

Tablets of 200 mg - pink

Suspension of 100 mg/5 ml

Prescribing Information

WARNING

APLASTIC ANEMIA AND AGRANULOCYTOSIS HAVE BEEN REPORTED IN ASSOCIATION WITH THE USE OF TEGRETOL. DATA FROM A POPULATION-BASED CASE CONTROL STUDY DEMONSTRATE THAT THE RISK OF DEVELOPING THESE REACTIONS IS 5-8 TIMES GREATER THAN IN THE GENERAL POPULATION. HOWEVER, THE OVERALL RISK OF THESE REACTIONS IN THE UNTREATED GENERAL POPULATION IS LOW. APPROXIMATELY SIX PATIENTS PER ONE MILLION POPULATION PER YEAR FOR AGRANULOCYTOSIS AND TWO PATIENTS PER ONE MILLION POPULATION PER YEAR FOR APLASTIC ANEMIA.

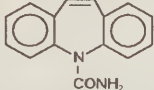
ALTHOUGH REPORTS OF TRANSIENT OR PERSISTENT DECREASED PLATELET OR WHITE BLOOD CELL COUNTS ARE NOT UNCOMMON IN ASSOCIATION WITH THE USE OF TEGRETOL, DATA ARE NOT AVAILABLE TO ESTIMATE ACCURATELY THEIR INCIDENCE OR OUTCOME. HOWEVER, THE VAST MAJORITY OF THE CASES OF LEUKOPENIA HAVE NOT PROGRESSED TO THE MORE SERIOUS CONDITIONS OF APLASTIC ANEMIA OR AGRANULOCYTOSIS.

BECAUSE OF THE VERY LOW INCIDENCE OF AGRANULOCYTOSIS AND APLASTIC ANEMIA, THE VAST MAJORITY OF MINOR HEMATOLOGIC CHANGES OBSERVED IN MONITORING OF PATIENTS ON TEGRETOL ARE UNLIKELY TO SIGNAL THE OCCURRENCE OF EITHER ABNORMALITY. NONETHELESS, COMPLETE PRETREATMENT HEMATOLOGICAL TESTING SHOULD BE OBTAINED AS A BASELINE. IF A PATIENT IN THE COURSE OF TREATMENT EXHIBITS LOW OR DECREASED WHITE BLOOD CELL OR PLATELET COUNTS, THE PATIENT SHOULD BE MONITORED CLOSELY. DISCONTINUATION OF THE DRUG SHOULD BE CONSIDERED IF ANY EVIDENCE OF SIGNIFICANT BONE MARROW DEPRESSION DEVELOPS.

Before prescribing Tegretol, the physician should be thoroughly familiar with the details of this prescribing information, particularly regarding use with other drugs, especially those which accentuate toxicity potential.

DESCRIPTION

Tegretol, carbamazepine USP, is an anticonvulsant and specific analgesic for trigeminal neuralgia, available for oral administration as chewable tablets of 100 mg, tablets of 200 mg, and as a suspension of 100 mg/5 ml (teaspoon). Its chemical name is 5*H*-dibenz[b,f]azepine-5-carboxamide, and its structural formula is:



Carbamazepine USP is a white to off-white powder, practically insoluble in water and soluble in alcohol and in acetone. Its molecular weight is 236.27.

Inactive Ingredients. Tablets: Colloidal silicon dioxide, D & C Red No. 30 Aluminum Lake (chewable tablets only), FO&C Red No. 40 (200-mg tablets only), flavoring (chewable tablets only), gelatin, glycerin, magnesium stearate, sodium starch glycolate (chewable tablets only), starch, stearic acid, and sucrose (chewable tablets only). Suspension: Citric acid, FO&C Yellow No.6, flavoring, polymer, potassium sorbate, propylene glycol, purified water, sorbitol, sucrose, and xanthan gum.

CLINICAL PHARMACOLOGY

In controlled clinical trials, Tegretol has been shown to be effective in the treatment of psychomotor and grand mal seizures, as well as trigeminal neuralgia.

It has demonstrated anticonvulsant properties in rats and mice with electrically and chemically induced seizures. It appears to act by reducing polysynaptic responses and blocking the post-tetanic potentiation. Tegretol greatly reduces or abolishes pain induced by stimulation of the infraorbital nerve in cats and rats. It depresses thalamic potential and bulbar and polysynaptic reflexes, including the linguomandibular reflex in cats. Tegretol is chemically unrelated to other anticonvulsants or other drugs used to control the pain of trigeminal neuralgia. The mechanism of action remains unknown.

In clinical studies both suspension and conventional tablet delivered equivalent amounts of drug to the systemic circulation. However, the suspension was absorbed somewhat faster than the tablet. Following a b.i.d. dosage regimen, the suspension has higher peak levels and lower trough levels than those obtained from the tablet formulation for the same dosage regimen. On the other hand, following a t.i.d. dosage regimen, Tegretol suspension affords steady-state plasma levels comparable to Tegretol tablets given b.i.d. when administered at the same total mg daily dose. Tegretol chewable tablets may produce higher peak levels than the same dose given as regular tablets. Tegretol in blood is 76% bound to plasma proteins. Plasma levels of Tegretol are variable and may range from 0.5-25 µg/ml, with no apparent relationship to the daily intake of the drug. Usual adult therapeutic levels are between 4 and 12 µg/ml. Following chronic oral administration of suspension, plasma levels peak at approximately 1.5 hours compared to 4 to 5 hours after administration of oral tablets. The CSF/serum ratio is 0.22, similar to the 22% unbound Tegretol in serum. Because Tegretol may induce its own metabolism, the half-life is also variable. Initial half-life values range from 25-65 hours, with 12-17 hours on repeated doses. Tegretol is metabolized in the liver. After oral administration of ¹⁴C-carbamazepine, 72% of the administered radioactivity was found in the urine and 28% in the feces. This urinary radioactivity was composed largely of hydroxylated and conjugated metabolites, with only 3% of unchanged Tegretol. Transplacental passage of Tegretol is rapid (30 to 60 minutes), and the drug is accumulated in fetal tissues, with higher levels found in liver and kidney than in brain and lungs.

INDICATIONS AND USAGE

Epilepsy: Tegretol is indicated for use as an anticonvulsant drug. Evidence supporting efficacy of Tegretol as an anticonvulsant was derived from active drug-controlled studies that enrolled patients with the following seizure types:

- Partial seizures with complex symptomatology (psychomotor, temporal lobe). Patients with these seizures appear to show greater improvement than those with other types.
- Generalized tonic-clonic seizures (grand mal).
- Mixed seizure patterns which include the above, or other partial or generalized seizures.

Absence seizures (petit mal) do not appear to be controlled by Tegretol (see PRECAUTIONS, General).

Trigeminal Neuralgia: Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia.

Beneficial results have also been reported in glossopharyngeal neuralgia.

This drug is not a simple analgesic and should not be used for the relief of trivial aches or pains.

CONTRAINDICATIONS

Tegretol should not be used in patients with a history of previous bone marrow depression, hypersensitivity to the drug, or known sensitivity to any of the tricyclic compounds, such as amitriptyline, desipramine, imipramine, protriptyline, nortriptyline, etc. Likewise, on theoretical grounds its use with monoamine oxidase inhibitors is not recommended. Before administration of Tegretol, MAO inhibitors should be discontinued for a minimum of fourteen days, or longer if the clinical situation permits.

WARNINGS

Patients with a history of adverse hematologic reaction to any drug may be particularly at risk.

Severe dermatologic reactions including toxic epidermal necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome, have been reported with Tegretol. These reactions have been extremely rare. However, a few fatalities have been reported.

Tegretol has shown mild anticholinergic activity; therefore, patients with increased intraocular pressure should be closely observed during therapy.

Because of the relationship of the drug to other tricyclic compounds, the possibility of activation of a latent psychosis and, in elderly patients, of confusion or agitation should be borne in mind.

PRECAUTIONS

General: Before initiating therapy, a detailed history and physical examination should be made.

Tegretol should be used with caution in patients with a mixed seizure disorder that includes atypical absence seizures, since in these patients Tegretol has been associated with increased frequency of generalized convulsions (see INDICATIONS AND USAGE).

Therapy should be prescribed only after critical benefit-to-risk appraisal in patients with a history of cardiac, hepatic or renal damage, adverse hematologic reaction to other drugs, or interrupted courses of therapy with Tegretol.

Since a given dose of Tegretol suspension will produce higher peak levels than the same dose given as the tablet, it is recommended that patients given the suspension be started on lower doses and increased slowly to avoid unwanted side effects (see OOSAGE AND ADMINISTRATION).

Information for Patients: Patients should be made aware of the early toxic signs and symptoms of a potential hematologic problem, such as fever, sore throat, rash, ulcers in the mouth, easy bruising, petechial or purpuric hemorrhage, and should be advised to report to the physician immediately if any such signs or symptoms appear.

Since dizziness and drowsiness may occur, patients should be cautioned about the hazards of operating machinery or automobiles or engaging in other potentially dangerous tasks.

Laboratory Tests: Complete pretreatment blood counts, including platelets and possibly reticulocytes and serum iron, should be obtained as a baseline. If a patient in the course of treatment exhibits low or decreased white blood cell or platelet counts, the patient should be monitored closely. Discontinuation of the drug should be considered if any evidence of significant bone marrow depression develops.

Baseline and periodic evaluations of liver function, particularly in patients with a history of liver disease, must be performed during treatment with this drug since liver damage may occur. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.

Baseline and periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended since many phenothiazines and related drugs have been shown to cause eye changes.

Baseline and periodic complete urinalysis and BUN determinations are recommended for patients treated with this agent because of observed renal dysfunction.

Monitoring of blood levels (see CLINICAL PHARMACOLOGY) has increased the efficacy and safety of anticonvulsants. This monitoring may be particularly useful in cases of dramatic increase in seizure frequency and for verification of compliance. In addition, measurement of drug serum levels may aid in determining the cause of toxicity when more than one medication is being used.

Thyroid function tests have been reported to show decreased values with Tegretol administered alone.

Hyponatremia has been reported in association with Tegretol use, either alone or in combination with other drugs.

Drug Interactions: The simultaneous administration of phenobarbital, phenytoin, or primidone, or a combination of two, produces a marked lowering of serum levels of Tegretol. The effect of valproic acid on Tegretol blood levels is not clearly established, although an increase in the ratio of active 10, 11-epoxide metabolite to parent compound is a consistent finding.

The half-lives of phenytoin, warfarin, doxycycline, and theophylline were significantly shortened when administered concurrently with Tegretol. Haloperidol and valproic acid serum levels may be reduced when these drugs are administered with Tegretol. The doses of these drugs may therefore have to be increased when Tegretol is added to the therapeutic regimen.

Concomitant administration of Tegretol with erythromycin, cimetidine, propoxyphene, terfenadine, isoniazid, fluoxetine or calcium channel blockers has been reported to result in elevated plasma levels of total and/or free carbamazepine resulting in toxicity in some cases. Also, concomitant administration of carbamazepine and lithium may increase the risk of neurotoxic side effects.

Alterations of thyroid function have been reported in combination therapy with other anticonvulsant medications.

Breakthrough bleeding has been reported among patients receiving concomitant oral contraceptives and their reliability may be adversely affected.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carbamazepine, when administered to Sprague-Oawley rats for two years in the diet at doses of 25, 75, and 250 mg/kg/day, resulted in a dose-related increase in the incidence of hepatocellular tumors in females and of benign interstitial cell adenomas in the testes of males.

Carbamazepine must, therefore, be considered to be carcinogenic in Sprague-Oawley rats. Bacterial and mammalian mutagenicity studies using carbamazepine produced negative results. The significance of these findings relative to the use of carbamazepine in humans is, at present, unknown.

Pregnancy Category C: Tegretol has been shown to have adverse effects in reproduction studies in rats when given orally in dosages 10-25 times the maximum human daily dosage of 1200 mg. In rat teratology studies, 2 of 135 offspring showed kinked ribs at 250 mg/kg and 4 of 119 offspring at 650 mg/kg showed other anomalies (cleft palate, 1; talipes, 1; anophthalmos, 2). In reproduction studies in rats, nursing offspring demonstrated a lack of weight gain and an unkempt appearance at a maternal dosage level of 200 mg/kg.

There are no adequate and well-controlled studies in pregnant women. Epidemiological data suggest that there may be an association between the use of carbamazepine during pregnancy and congenital malformations, including spina bifida. Tegretol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Retrospective case reviews suggest that, compared with monotherapy, there may be a higher prevalence of teratogenic effects associated with the use of anticonvulsants in combination therapy.

Therefore, monotherapy is recommended for pregnant women.

It is important to note that anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

Labor and Delivery: The effect of Tegretol on human labor and delivery is unknown.

Nursing Mothers: During lactation, concentration of Tegretol in milk is approximately 60% of the maternal plasma concentration.

Because of the potential for serious adverse reactions in nursing infants from carbamazepine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children below the age of 6 years have not been established.

ADVERSE REACTIONS

If adverse reactions are of such severity that the drug must be discontinued, the physician must be aware that abrupt discontinuation of any anticonvulsant drug in a responsive epileptic patient may lead to seizures or even status epilepticus with its life-threatening hazards.

The most severe adverse reactions have been observed in the hemopoietic system (see boxed WARNING), the skin and the cardiovascular system.

The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea, and vomiting. To minimize the possibility of such reactions, therapy should be initiated at the low dosage recommended.

The following additional adverse reactions have been reported: **Hemopoietic System:** Aplastic anemia, agranulocytosis, pancytopenia, bone marrow depression, thrombocytopenia, leukopenia, leukocytosis, eosinophilia, acute intermittent porphyria.

Skin: Pruritic and erythematous rashes, urticaria, toxic epidermal necrolysis (Lyell's syndrome) (see WARNINGS), Stevens-Johnson syndrome (see WARNINGS), photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, erythema multiforme and nodosum, purpura, aggravation of disseminated lupus erythematosus, alopecia, and diaphoresis. In certain cases, discontinuation of therapy may be necessary. Isolated cases of hirsutism have been reported, but a causal relationship is not clear.

Cardiovascular System: Congestive heart failure, edema, aggravation of hypertension, hypotension, syncope and collapse, aggravation of coronary artery disease, arrhythmias and AV block, primary thrombophlebitis, recurrence of thrombophlebitis, and adenopathy or lymphadenopathy.

Some of these cardiovascular complications have resulted in fatalities. Myocardial infarction has been associated with other tricyclic compounds.

Liver: Abnormalities in liver function tests, cholestatic and hepatocellular jaundice, hepatitis.

Respiratory System: Pulmonary hypersensitivity characterized by fever, dyspnea, pneumonitis or pneumonia.

Genitourinary System: Urinary frequency, acute urinary retention, oliguria with elevated blood pressure, azotemia, renal failure, and impotence. Albuminuria, glycosuria, elevated BUN and microscopic deposits in the urine have also been reported.

Testicular atrophy occurred in rats receiving Tegretol orally from 4 to 52 weeks at dosage levels of 50 to 400 mg/kg/day. Additionally, rats receiving Tegretol in the diet for two years at dosage levels of 25, 75, and 250 mg/kg/day had a dose-related incidence of testicular atrophy and aspermatogenesis. In dogs, it produced a brownish discoloration, presumably a metabolite, in the urinary bladder at dosage levels of 50 mg/kg and higher. Relevance of these findings to humans is unknown. **Nervous System:** Dizziness, drowsiness, disturbances of coordination, confusion, headache, fatigue, blurred vision, visual hallucinations, transient diplopia, oculomotor disturbances, nystagmus, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, tinnitus, and hyperacusis.

There have been reports of associated paralysis and other symptoms of cerebral arterial insufficiency, but the exact relationship of these reactions to the drug has not been established.

Digestive System: Nausea, vomiting, gastric distress and abdominal pain, diarrhea, constipation, anorexia, and dryness of the mouth and pharynx, including glossitis and stomatitis.

Eyes: Scattered punctate cortical lens opacities, as well as conjunctivitis, have been reported. Although a direct causal relationship has not been established, many phenothiazines and related drugs have been shown to cause eye changes.

Musculoskeletal System: Aching joints and muscles, and leg cramps. **Metabolism:** Fever and chills. Inappropriate antidiuretic hormone (ADH) secretion syndrome has been reported. Cases of frank water intoxication, with decreased serum sodium (hyponatremia) and confusion, have been reported in association with Tegretol use (see PRECAUTIONS, Laboratory Tests).

Other: Isolated cases of a lupus erythematosus-like syndrome have been reported. There have been occasional reports of elevated levels of cholesterol, HOL cholesterol and triglycerides in patients taking anticonvulsants.

A case of aseptic meningitis, accompanied by myoclonus and peripheral eosinophilia, has been reported in a patient taking carbamazepine in combination with other medications. The patient was successfully dechallenged, and the meningitis reappeared upon rechallenge with carbamazepine.

DRUG ABUSE AND DEPENDENCE

No evidence of abuse potential has been associated with Tegretol, nor is there evidence of psychological or physical dependence in humans.

OVERDOSAGE

Acute Toxicity

Lowest known lethal dose: adults, >60 g (39-year-old man). Highest known doses survived: adults, 30 g (31-year-old woman); children, 10 g (6-year-old boy); small children, 5 g (3-year-old girl).

Oral LD₅₀ in animals (mg/kg): mice, 1100-3750; rats, 3850-4025; rabbits, 1500-2680; guinea pigs, 920.

Signs and Symptoms

The first signs and symptoms appear after 1-3 hours. Neuromuscular disturbances are the most prominent. Cardiovascular disorders are generally milder, and severe cardiac complications occur only when very high doses (>60 g) have been ingested.

Respiration: Irregular breathing, respiratory depression. **Cardiovascular System:** Tachycardia, hypotension or hypertension, shock, conduction disorders.

Nervous System and Muscles: Impairment of consciousness ranging in severity to deep coma. Convulsions, especially in small children. Motor restlessness, muscular twitching, tremor, athetoid movements, opisthotonos, ataxia, drowsiness, dizziness, mydriasis, nystagmus, adiadochokinesia, ballism, psychomotor disturbances, dysmetria. Initial hyperreflexia, followed by hyporeflexia.

Gastrointestinal Tract: Nausea, vomiting.

Kidneys and Bladder: Anuria or oliguria, urinary retention.

Laboratory Findings: Isolated instances of overdosage have included leukocytosis, reduced leukocyte count, glycosuria and acetonuria. EEG may show dysrhythmias.

Combined Poisoning: When alcohol, tricyclic antidepressants, barbiturates or hydantoin are taken at the same time, the signs and symptoms of acute poisoning with Tegretol may be aggravated or modified.

Treatment

The prognosis in cases of severe poisoning is critically dependent upon prompt elimination of the drug, which may be achieved by inducing vomiting, irrigating the stomach, and by taking appropriate steps to diminish absorption. If these measures cannot be implemented without risk on the spot, the patient should be transferred at once to a hospital, while ensuring that vital functions are safeguarded. There is no specific antidote. **Elimination of the Drug:** Induction of vomiting.

Gastric lavage. Even when more than 4 hours have elapsed following ingestion of the drug, the stomach should be repeatedly irrigated, especially if the patient has also consumed alcohol. **Measures to Reduce Absorption:** Activated charcoal, laxatives. **Measures to Accelerate Elimination:** Forced diuresis.

Olysis is indicated only in severe poisoning associated with renal failure. Replacement transfusion is indicated in severe poisoning in small children.

Respiratory Depression: Keep the airways free; resort, if necessary, to endotracheal intubation, artificial respiration, and administration of oxygen.

Hypotension, Shock: Keep the patient's legs raised and administer a plasma expander. If blood pressure fails to rise despite measures taken to increase plasma volume, use of vasoactive substances should be considered.

Convulsions: Diazepam or barbiturates.

Warning: Diazepam or barbiturates may aggravate respiratory depression (especially in children), hypotension, and coma. However, barbiturates should not be used if drugs that inhibit monoamine oxidase have also been taken by the patient either in overdosage or in recent therapy (within one week).

Surveillance: Respiration, cardiac function (ECG monitoring), blood pressure, body temperature, pupillary reflexes, and kidney and bladder function should be monitored for several days.

Treatment of Blood Count Abnormalities: If evidence of significant bone marrow depression develops, the following recommendations are suggested: (1) stop the drug, (2) perform daily CBC, platelet and reticulocyte counts, (3) do a bone marrow aspiration and trephine biopsy immediately and repeat with sufficient frequency to monitor recovery.

Special periodic studies might be helpful as follows: (1) white cell and platelet antibodies, (2) ⁵⁹Fe —ferrokinetic studies, (3) peripheral blood cell typing, (4) cytogenetic studies on marrow and peripheral blood, (5) bone marrow culture studies for colony-forming units, (6) hemoglobin electrophoresis for A₂ and F hemoglobin, and (7) serum folic acid and B₁₂ levels.

A fully developed aplastic anemia will require appropriate, intensive monitoring and therapy, for which specialized consultation should be sought.

DOSAGE AND ADMINISTRATION (see table below)

Monitoring of blood levels has increased the efficacy and safety of anticonvulsants (see PRECAUTIONS, Laboratory Tests). Oosage should be adjusted to the needs of the individual patient. A low initial daily dosage with a gradual increase is advised. As soon as adequate control is achieved, the dosage may be reduced very gradually to the minimum effective level. Medication should be taken with meals.

Since a given dose of Tegretol suspension will produce higher peak levels than the same dose given as the tablet, it is recommended to start with low doses (children 6-12 years: 1/2 teaspoon q.i.d.) and to increase slowly to avoid unwanted side effects.

Conversion of patients from oral Tegretol tablets to Tegretol suspension: Patients should be converted by administering the same number of mg per day in smaller, more frequent doses (i.e., b.i.d. tablets to t.i.d. suspension).

Epilepsy (see INDICATIONS AND USAGE)

Adults and children over 12 years of age — Initial: Either 200 mg b.i.d. for tablets or 1 teaspoon q.i.d. for suspension (400 mg per day). Increase at weekly intervals by adding up to 200 mg per day using a t.i.d. or q.i.d. regimen until the optimal response is obtained. Oosage generally should not exceed 1000 mg daily in children 12 to 15 years of age, and 1200 mg daily in patients above 15 years of age. Ooses up to 1600 mg daily have been used in adults in rare instances.

Maintenance: Adjust dosage to the minimum effective level, usually 800-1200 mg daily.

Children 6-12 years of age — Initial: Either 100 mg b.i.d. for tablets or 1/2 teaspoon q.i.d. for suspension (200 mg per day). Increase at weekly intervals by adding up to 100 mg per day using a t.i.d. or q.i.d. regimen until the optimal response is obtained. Oosage generally should not exceed 1000 mg daily. **Maintenance:** Adjust dosage to the minimum effective level, usually 400-800 mg daily.

Combination Therapy: Tegretol may be used alone or with other anticonvulsants. When added to existing anticonvulsant therapy, the drug should be added gradually while the other anticonvulsants are maintained or gradually decreased, except phenytoin, which may have to be increased (see PRECAUTIONS, Drug Interactions and Pregnancy Category C).

Trigeminal Neuralgia (see INDICATIONS AND USAGE)

Initial: On the first day, either 100 mg b.i.d. for tablets or 1/2 teaspoon q.i.d. for suspension for a total daily dose of 200 mg. This daily dose may be increased by up to 200 mg a day using increments of 100 mg every 12 hours for tablets or 50 mg (1/2 teaspoon) q.i.d. for suspension, only as needed to achieve freedom from pain. Oo not exceed 1200 mg daily.

Maintenance: Control of pain can be maintained in most patients with 400 mg to 800 mg daily. However, some patients may be maintained on as little as 200 mg daily, while others may require as much as 1200 mg daily. At least once every 3 months throughout the treatment period, attempts should be made to reduce the dose to the minimum effective level or even to discontinue the drug.

HOW SUPPLIED

Chewable Tablets 100 mg —round, red-speckled, pink, single-scored (imprinted Tegretol on one side and 52 twice on the scored side)

Bottles of 100.....NOC 58887-052-30

Unit Oose (blister pack)

Box of 100 (strips of 10).....NOC 58887-052-32

Do not store above 86°F (30°C). *Protect from light and moisture.*

Dispense in tight, light-resistant container (USP).

Tablets 200 mg — capsule-shaped, pink, single-scored (imprinted Tegretol on one side and 27 twice on the partially scored side)

Bottles of 100.....NOC 58887-027-30

Bottles of 1000.....NDC 58887-027-40

Unit Oose (blister pack)

Box of 100 (strips of 10).....NOC 58887-027-32

Do not store above 86°F (30°C).

Protect from moisture. Dispense in tight container (USP).

Samples, when available, are identified by the word **SAMPLE** appearing on each tablet.

Suspension 100 mg/5 ml (teaspoon) — yellow-orange, citrus-vanilla flavored

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Dosage Information: Tablets and Suspension					
Indication	Initial Dose		Subsequent Dose		Maximum Dose
	Tablet	Suspension	Tablet	Suspension	Tablet or Suspension
Epilepsy					
6-12 years of age	100 mg b.i.d. (200 mg/day)	1/ 2 teaspoon q.i.d. (200 mg/day)	Add up to 100 mg per day at weekly intervals, t.i.d. or q.i.d.	Add up to 1 teaspoon (100 mg) per day at weekly intervals, t.i.d. or q.i.d.	1000 mg/24 hours
Over 12 years of age	200 mg b.i.d. (400 mg/day)	1 teaspoon q.i.d. (400 mg/day)	Add up to 200 mg per day at weekly intervals, t.i.d. or q.i.d.	Add up to 2 teaspoons (200 mg) per day at weekly intervals, t.i.d. or q.i.d.	1000 mg/24 hours: 12-15 years 1200 mg/24 hours: over 15 years 1600 mg/24 hours: adults, in rare instances
Trigeminal Neuralgia	100 mg b.i.d. on the first day (200 mg/day)	1/ 2 teaspoon q.i.d. (200 mg/day)	Add up to 200 mg per day in increments of 100 mg every 12 hours	Add up to 2 teaspoons (200 mg) per day q.i.d.	1200 mg/24 hours

Budget

(Continued from page 1)

ment's Teen Parent Initiative, one of Edgar's welfare reform proposals, Schott said. Under the program, mothers age 18 and under are required to complete their high school education as a condition of receiving public assistance. "The Teen Parent Initiative survived, and we're excited about that," Schott said. "We're moving forward with implementation and expect to take the program statewide."

Also faring well in the budget were the Illinois Department of Public Health, the Department of Alcohol and Substance Abuse and the Department of Mental Health and Developmental Disabilities.

IDPH received increased funding for priority initiatives including the Women, Infants and Children program, HIV/AIDS prevention programs and Local Health Protection grants. The grants will be increased by \$308,000 and will fund three new local health departments in the developmental stage, as well as the five local health departments expected to complete the certification process this year, according to IDPH. The only significant cut was for the purchase of equipment, which will affect the statewide rollout of Cornerstone, IDPH's integrated maternal and child health information system, a department spokesperson said.

"We are pleased that despite major budget pressures, the core public health programs survived intact," said IDPH Director John Lumpkin, MD.

With a \$6.7-million increase in funding for alcohol and substance abuse treatment for parents involved in child abuse and neglect cases, DASA will be able to double the number of services available to Department of Children and Family Services clients in need of treatment, said Tom Green, a department spokesperson. "We're very pleased about the increase in funding for treatment. We feel it is most important because when you look at the statistics, they show the majority of child abuse and neglect cases reported involve alcohol and other drug-related problems."

DASA also received a \$1-million funding increase for gang violence prevention programs in several metropolitan areas and \$435,000 for a women's residential treatment program in Aurora. "Overall, there was a 47-percent increase in our budget when you include Medicaid," Green said.

All requested program initiatives or program expansions in the \$1.08-billion DMHDD budget survived the budget process. Overall, legislators appropriated a \$73-million boost in mental health funding that will be used for programs and services to help patients move from institutions and nursing homes into community living arrangements, according to the governor's office.

"This increase for DMHDD is something to celebrate in a year when the General Assembly looked long and hard for reductions in state agency budgets," said Lynn Handy, acting DMHDD director. "Most importantly, this budget preserves the themes of our system reform, expanding community services while maintaining resources for state-operated facilities."

DMHDD can now proceed in integrating the various components of the mental health system under a managed care plan, Handy said. "This will draw together programs administered by the

departments of Mental Health and Developmental Disabilities, Children and Family Services, Public Aid and Alcohol and Substance Abuse. Under this plan, clients will experience better linkage among services and will have more direct access to the most appropriate services for treatment needs. This will also enable the state to make better use of existing general revenue funds."

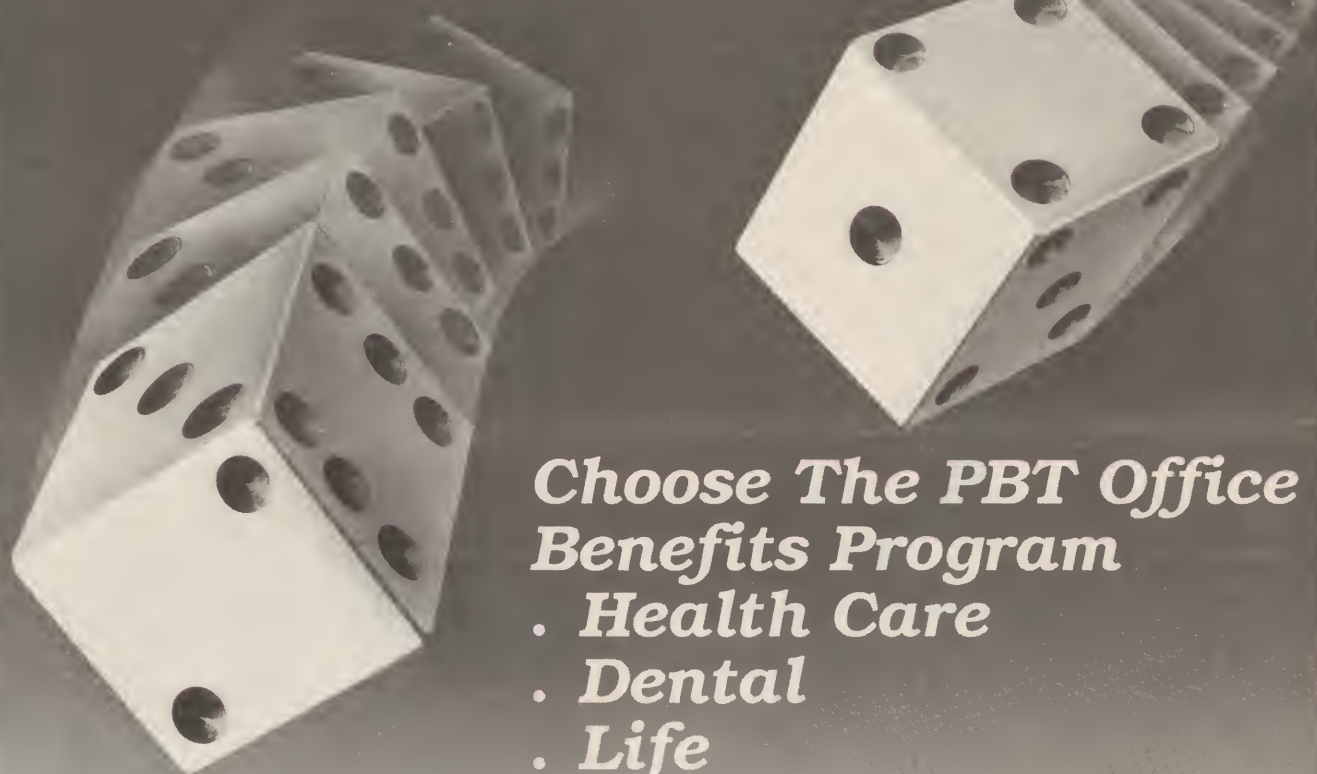
In addition, DMHDD received sufficient funding to improve staff-to-recipient ratios in state-operated facilities, Handy said. "By the end of fiscal 1995, we will achieve ratios averaging 1.98-to-1, an increase of 17 percent over fiscal 1994 ratios." ■



Carla Sommerfeld

KEN RYAN, director of ISMS' economics department, is the most recent winner of the Society's bimonthly award recognizing outstanding employee service. Ryan was honored for helping physicians resolve difficulties with third-party payers.

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FIRST OF TWO PARTS

Clearing the hurdle of managed care contracts

According to attorneys, physicians can effectively negotiate terms.

BY KATHLEEN FURORE

Should I sign this managed care contract? That's the question posed more and more often by physicians inundated with forms from managed care plans. And it's easy for medical professionals – fearful of losing access to patients – to leap into managed care agreements without looking at the fine print in the contracts they're signing.

"Often providers sign contracts without careful review and meaningful discussion with the managed care entity," said Anne M. Murphy, an attorney at Chicago's Vedder, Price, Kaufman & Kammholz and a participant in ISMS' new Lawyer Referral Network. "There's a lot of uncertainty in the marketplace and an unfamiliarity with what a contract should look like."

That lack of familiarity, along with the technical nature of managed care documents, makes it difficult for physicians to recognize what's appropriate in a contract and what they might want to change, Murphy said. In addition, the disparities between what is best for providers and what is financially prudent for managed care entities can create problems for physicians, she noted.

Murphy stressed, however, that both negotiating parties have considerable flexibility to reach agreement on the most significant terms in contracts. "As providers become more experienced and increasingly form their own networks, their input into the formulation of contracts is becoming more prevalent."

Although the specific considerations can vary by market and specialty, there are some universal areas physicians should understand and discuss before signing a contract. Without that scrutiny, the managed care entity will likely benefit, she explained. "Physicians have to remember that they're dealing with potentially large insurance companies that aren't necessarily going to be receptive at the outset to negotiat-

ing intensively. But some of the contracts presented are heavily weighted in the companies' favor. They're contracts drafted by their attorneys and give the companies the advantage. That's why contracts can and should be reviewed by the providers. It's important for providers to consider what their [liability] exposure is and what their obligations are."

JUST WHAT ISSUES should be covered in contract discussions? Basic obligations and responsibilities, indemnification and termination are among the areas of most concern to doctors, according to attorneys who have represented physicians in managed care contract negotiations.

Fully understanding what the plan expects of its providers is a basic but critical aspect of reviewing managed care contracts, said Thomas J. Reed, an

ISMS referral service offers contract assistance

Physicians can receive help with contract review and negotiations through ISMS' Lawyer Referral Network. The network is composed of more than 60 Illinois attorneys with experience in health care and a history of physician advocacy. In addition to assisting with contracts, the lawyers participating in the referral network can provide counsel in such areas as managed care, licensure, medical staff issues, Medicare and Medicaid, taxes, and fraud and abuse concerns. All network attorneys have agreed to provide legal counsel to ISMS members at discounted rates.

To access the referral network, physicians should call the ISMS managed care action line at (800) MD-ASIST. ISMS legal staff will assess physicians' needs and refer them to attorneys who can specifically handle them. ■

FIRST OF TWO PARTS



Patrick Whelan

attorney in private practice in Chicago and a participant in the ISMS Lawyer Referral Network. Although it may seem like a simple step, there are often hidden roadblocks physicians could face later if they are unfamiliar with contracts, Reed said. "Sometimes an explanation of providers' obligations and responsibilities is appended to the contract. But in some cases, things like quality assurance and utilization review manuals that were prepared by the managed care entity are just referred to. And even if you've never seen the documents that describe your obligations, you're responsible for what they say."

Reed also suggested that physicians reviewing contracts should compile lists of any documents referenced but not included in the contract. Then, ask to see all of those pertinent documents before signing, he advised. "It's also a good idea to find out if doctors were involved in the preparation of [quality assurance and utilization review] manuals."

Indemnification is another key issue, according to Judee Gallagher, an attorney in private practice in

Chicago and a participant in the ISMS Lawyer Referral Network. "Indemnification is basically a promise to pay someone else's bills," Gallagher explained. "If you sign a contract with indemnity and the plan is sued for negligence due to medical care, you could be responsible for the cost of defense and any judgment against the plan." When that happens, a physician's personal assets are in danger, since malpractice insurance policies specifically exclude liabilities assumed when a contract is signed, she noted.

Because of the high risks associated with indemnification, Gallagher advised physicians to ensure that any contracts they're considering are reviewed by someone who thoroughly understands the issue. "An indemnification clause is sometimes easy to recognize. If you see the word 'indemnify' or the phrase 'indemnify and hold harmless,' your contract contains an indemnification. But indemnification also may be implied by statements that make you responsible for someone else's actions."

Contracts can also contain clauses that indemnify providers for administrative services as well as medical care, Gallagher said. "This doesn't eliminate your financial exposure, since payment decisions often become inseparable from decisions regarding treatment the patient receives and make it impossible to separate medical care from administrative services."

Gallagher suggested that physicians negotiate with managed care entities to remove indemnification clauses from contracts and closely monitor any new contracts issued by the managed care company. "The insurance industry takes indemnification out when

we insist and then puts it back in when a new contract is generated," she cautioned.

PHYSICIANS SHOULD ALSO be certain that the organizations with which they contract maintain adequate professional liability insurance to cover suits filed because of their credentialing, utilization review or other cost-containment mechanisms. "Even if your contractor has promised to indemnify you and hold you harmless from liabilities resulting from its activities, this promise may be meaningless if your contractor can't pay for damages. You could be seen as the deep pocket. Under joint and several liability law, if you and your contractor are found to share liability, you could be responsible for the entire judgment if your contractor is unable to pay its share," Gallagher explained.

Most physicians entering managed care agreements are concerned about termination provisions, especially in light of reports about doctors who have lost sub-

(Continued on page 14)

Contracts

(Continued from page 13)

stantial percentages of their patient base when they were terminated without cause. Although those concerns are justified, physicians should realize that the right to terminate a contract can actually help them in many cases, Gallagher said. "Termination provisions are not necessarily bad for doctors. Although you do hear about cases of physicians being terminated without cause, doctors frequently use the provisions to get out of

contracts when they're dissatisfied with things like payment and quality issues."

She noted, however, that the benefits of termination-without-cause provisions depend on the number of patients a physician has in a particular plan. "A lot of my clients use termination-without-cause to protect themselves. They might say, 'Why do I need the aggravation when only 7 percent of my patients are in this plan?'" Gallagher said, citing one physician who used termination-without-cause to leave a plan that started reimbursing at rates below those paid by

Medicare. "But when a large percent of a doctor's patient base is concentrated in one plan – in areas where there is one big employer that operates a plan, for example – there is more danger in termination-without-cause agreements."

"Termination provisions can be particularly important to a provider if the original contract negotiations didn't result in favorable terms in significant areas," Murphy noted. "For example, where a provider has become dissatisfied with the contractual relationships in such areas as claims payment or utiliza-

tion review, termination of the relationship without cause is the most desirable remedy." Physicians should at least negotiate what she calls a mutual right of termination, Murphy said. "If the managed care organization can quit you, you should be in a position to quit the organization."

MOST CONTRACTS CONTAIN termination-with-cause and termination-without-cause provisions. Termination with cause applies when either the contractor or the provider has not performed obligations spelled out in the contract, Gallagher explained. Termination-with-cause provisions should cover the most likely breaches and the dispute resolution processes that could be set in motion if disagreements arise about the cause of termination, Murphy noted.

Other termination provisions to consider include physicians' rights and responsibilities after the contract has ended, according to attorneys who review contracts. Murphy, Gallagher and Reed all advise physicians to determine whether plans can transfer patients upon notice of contract termination or whether the doctors must continue caring for some patients. This is important, since a malpractice claim could arise if injury results from failure to continue treatment through a period of later complications, they said. In addition, physicians should determine whether contracts prohibit them from competing with the managed care plan after termination, the attorneys added. ■

Negotiating physician-friendly contract terms

Success in negotiating contracts with managed care entities depends on several factors, including physicians' professional reputation, their specialty and the local marketplace, according to attorneys who deal with health care contracts. But they encourage all physicians to bring their concerns and proposed changes to the bargaining table.

The following examples illustrate types of issues that can be resolved when physicians use their bargaining power and realize that contract provisions proposed by managed care entities aren't always set in stone.

A managed care plan sought a capitated arrangement with local orthopedic surgeons. The entity attempted to

recruit a two-physician practice, which it perceived as being superior to other area orthopedic surgical practices, said Chicago attorney Judee Gallagher, a participant in ISMS' Lawyer Referral Network. Gallagher explained that during negotiations, the orthopedic surgeons leveraged the practice's stellar reputation into terms that benefited the physicians in a way the originally proposed capitation arrangement did not. "We negotiated and said that the capitation had to equal a certain percent of the group's fee schedule and that the [difference] between the percent of the fee schedule and the capitation received had to be reconciled every six months."

Gallagher also described the negotiating success of a radiology group considering a managed care contract. The physicians in the group did not want to perform mammograms as part of the capitated contract because of how frequently the tests are performed, she noted. In the end, the doctors convinced the managed care entity to carve out mammography services from the capitation agreement, and they were permitted to refer patients to another practice for mammograms, Gallagher said. A similar tactic can be used to carve out other expensive procedures from capitation contracts and receive payment for those procedures on a fee-for-service basis, she added. ■

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Market research

(Continued from page 1)

ual patients, she added. In addition, specialists should consider their relationship with primary care physicians, since that will be the source of most referrals.

BEGIN BY REVIEWING the practice's patient and payer mix, advised Anwar and Gill. Patient records should contain all the necessary information about patients and payers, including chief complaints, diagnoses, ages, insurance and addresses, Anwar said.

Physicians can conduct the practice studies themselves, but they may need demographics training, Anwar continued. Outside consultants can help relate the studies to physicians' goals and pull numbers together, she noted, adding that the cost generally depends on the size of the practice.

"Physicians need to look at where the revenue is coming from," Gill explained. The best way to view this information is in the form of a pie chart, which can be created using any basic statistical software or hand-calculated, she said. The pie chart will show the mix of patients who have traditional indemnity insurance and discounted indemnity coverage, such as through PPOs, as well as those who are members of HMOs.

Once physicians have current pie charts on payer mixes, they should trace the information back five years to see what has changed, according to Gill. Then they can project the payer mix for the next three to five years, "making certain assumptions," she noted. For example, physicians may consider participation in HMOs and acceptance of certain HMO fee schedules.

Part of the process of reviewing payers is determining revenue-to-expense trends "a couple of years back and forward," Gill continued. In general, physicians may see their revenue decreasing and expenses rising. "[Physicians] report working harder for the same or less revenue. The office expenses may be greater, or the discounts may be larger."

THE NEXT STEP is to review the patient base geographically to gather information for developing marketing strategies, Anwar said. Marketing can help physicians retain their current patients and attract new ones. To get a complete picture of their practice, physicians must analyze variables such as where patients live, where they work, who referred them to the practice and what disease entities they have, Anwar said.

Such geographic analysis begins by dividing patients according to their ZIP codes, which are listed in their medical records, Anwar said. Physicians can use this information to determine the "catchment areas" for their patients, she said. For instance, doctors can determine how many patients live within 5 miles of the practice and within 10 miles, she explained. Armed with that information, physicians can market their services to targeted areas in which they have the most patients.

Physicians should also identify patients' employers, Anwar said. A physician's practice base may be spread over a wide geographic area, but the patients may be employed by one or only a few companies. In such cases, Anwar recommends that physicians contact the companies' human resources departments to arrange health screenings or other services that can help maintain contacts with current

Talk to Medicaid patients before redetermination

With Medicaid patients facing choices about who provides their medical care, it is essential for physicians to talk to these patients about the value of existing doctor-patient relationships, said ISMS President Alan M. Roman, MD. Reinforcing this message is more important than ever, since the General Assembly passed Gov. Jim Edgar's Medicaid reform proposal, which is designed to shift more than 1 million public aid patients into managed care, Dr. Roman added.

"A physician is the logical person to provide needed information about continuity in health care," Dr. Roman said. "If physicians want to maintain their current Medicaid patients, they must speak up about it. When these patients come into the office, doctors should take the time to tell them how much they value the relationship."

As usual, Medicaid recipients will meet with Illinois Department of Public Aid staff to determine whether they will be eligible for continuing benefits. During these annual interviews, recipients are asked to choose a physician, an HMO or a Federally Qualified Health Center.

Primary care physicians who participate in the state's Healthy Moms/Healthy Kids program should begin talking with their patients immediately, Dr. Roman noted. IDPA is in the process of implementing a demonstration project aimed at promoting enrollment of Medicaid patients in HMOs. As proposed, the project calls for automatic assignment to an HMO for some of those Medicaid recipients who are eligible for Healthy Moms/Healthy Kids and who fail to select a specific primary care provider during their redetermination of benefits meeting.

When the project is under way, IDPA will send letters to some Healthy Moms/Healthy Kids enrollees who failed to make a choice during their last redetermination interview, said IDPA. Those letters will inform recipients that they have been assigned to a provider.

"The passage of the Medicaid reform package underscores the importance of physician-patient communication," Dr. Roman said. "Unless patients supply IDPA with the name of the physician they choose, there is no guarantee they can continue an existing relationship."

Also, if patients in the Healthy Moms/Healthy Kids program make no selection at all, they may not be able to see their same doctor."

To help patients remain with the physician of their choice, physicians – especially HMK participants – should provide their patients with the full name and address of their practice, Dr. Roman said. Physicians should advise their patients to present the information during their annual redetermination of benefits interview. Patients who provide this information will automatically be reassigned to their current primary care physician, as long as that doctor has not exceeded the number of patients he or she has agreed to treat, according to IDPA.

"Physicians must continuously talk to their Medicaid patients about their desire to preserve their relationship, since there is no way to ascertain when individual recipients are scheduled for their redetermination interviews," Dr. Roman stressed. "For the caring physicians who participate in the Medicaid program, these discussions should be nothing more than an extension of the quality care they already provide." ■

patients and attract potential ones.

"If your patients come from one big employer, overnight your insurance pattern could change. I'm always astonished at how dependent physicians are on a few sources of patients," Gill added.

The geographic analysis should also include referral sources for patients, Anwar said. If some referrals are coming from areas outside physicians' main patient base, they should learn more about those areas to begin developing marketing strategies, including identifying the primary care gatekeepers and targeting their patients.

Physicians may also want to identify the specific disease entities of their patients, Anwar added. This is important if most referrals are for a specific treat-

ment. For example, a general surgeon may be known in the community for performing hernia repairs. But that surgeon is probably skilled in other techniques, which need to be marketed, she said.

If physicians discover they have no patients from certain geographic areas that are close to their practices, they should find out why, Anwar said. "If they are not getting patients from one area, it may be because it is oversaturated with that type of specialist. Physicians also need to look at their competition." They can identify other physicians in the area from hospital directories, specialty societies or the phone book.

The state census bureau can also provide information regarding the potential patient base surrounding physicians'

practices, Anwar noted. In addition, the AMA and specialty societies can provide breakdowns of the number of patients necessary to keep a practice viable.

In addition, ISMS is developing consultant referral services to help meet physicians' needs. The Society is soliciting information from members about their positive experiences with managed care consultants. To recommend consultants for the ISMS referral network, members may call the Society's managed care action line at (800) MD-ASIST.

"If physicians feel overwhelmed, that's normal," Gill said. "Learning about managed care is like learning a new language. But the literature is getting increasingly better." ■

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MEMBERS IN THE NEWS

Peter McKinney, MD, a plastic surgeon in Chicago, has presented a variety of lectures, courses and papers.



Dr. McKinney

Most recently, he taught courses in adjunctive rhinoplasty, blepharoplasty and reconstruction of the nasal dorsum at the Midwest Association of Plastic Surgeons' 24th Symposium on Aesthetic Plastic Surgery at the University of Toronto in mid-May.

In April, Dr. McKinney presented a paper about research in chemical peeling and taught two teaching courses on rhinoplasty and rhytidectomy during the annual meeting of the American Society of Aesthetic Plastic Surgeons in Dallas. Earlier in the year, he lectured in Philadelphia and in Chicago at the 50th annual Midwest Clinical Conference of the Chicago Medical Society.

In recognition of his contributions to the diagnosis, treatment and study of multiple personality and dissociation, Robert DeVito, MD, was awarded a fellowship in the International Society for the Study of MPD. Dr. DeVito, pro-

fessor and chairman of the psychiatry department at Loyola University Medical Center in Maywood, is one of only 29 individuals to achieve fellowship status in the 3,050-member society.

In addition to his work at Loyola, Dr. DeVito is chief of the psychiatry service at Loyola's Foster G. McGaw Hospital, senior psychiatric consultant at the Department of Veterans Affairs Edward Hines Jr. Hospital and vice chairman of the Chicago Consortium for Psychiatric Research.

Catherine Kallal, MD, is the newly appointed director of Illinois Masonic Medical Center's internal medicine residency program in Chicago. In her new position, Dr. Kallal will oversee the clinical, research and educational activities of Illinois Masonic's internal medicine residents. Previously, she was medical director of the Woodlawn Adult Health Center and served as chairman of Provident Hospital's department of internal medicine.

Dr. Kallal, of Evanston, is a graduate of Boston University and the Loyola University Stritch School of Medicine. She has served as co-director of Cook County Hospital's primary care internal medicine residency program, acting chair of Cook County's division of

internal medicine and director of the hospital's Medical Consultation Service. Dr. Kallal is also a two-time recipient of the Best Clinical Teacher Award from Cook County. She has received several grants for developing and implementing programs for community-based health services and worked as a National Health Service Corps physician in a neighborhood health center in Arizona.

The American Academy of Orthopaedic Surgeons elected James Hill, MD, to its board of directors during the organization's annual meeting in New Orleans. Dr. Hill is an associate professor of clinical orthopedic surgery at Northwestern University Medical School and is an active attending physician at Northwestern Memorial Hospital.

The American Academy of Orthopaedic Surgeons is a 20,000-member not-for-profit organization that offers educational programs for orthopedic surgeons and the public, and advocates for improved patient care.

Several ISMS members were recently elected to leadership positions on the medical staff of Anderson Hospital in Maryville. In addition, the hospital announced that five new physicians

joined the staff, all of whom are ISMS members.

The 1994 medical staff officers, who were confirmed by the hospital's board of trustees, represent the 170-plus physicians on Anderson's staff. The doctors, all of whom are from Edwardsville, are internist Tibor Kopjas, MD, president; orthopedic surgeon S.F. Chen, MD, vice president; pediatrician Angela Bard, MD, secretary; and family practitioner Patrick Zimmermann, MD, treasurer.

Members at large include Jose Diaz Jr., MD, a general, vascular and thoracic surgeon from Highland; K. Max Eakin, MD, a family practitioner from Edwardsville; Mark Fedder, MD, a gastroenterologist from Collinsville; Michael Rallo, MD, a family practitioner from Glen Carbon; and Yogendra Shah, MD, an Ob/Gyn from St. Louis.

New to the medical staff are family practitioners Donna Boone, MD; Dolores Cantrell, MD; and Rodney Lupardus, MD – who have opened a practice in Edwardsville. Also joining Anderson's staff are Abdul Kazi, MD, who specializes in pulmonary thoracic surgery and has an office in Belleville, and Alan Stein, MD, a urologist with an office in Edwardsville. ■

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MEDICAL CENTER,
4550 N. Winchester,
Chicago, IL 60640. EOE.**



Doctors and lawmakers

(Continued from page 1)

care reform debate. "I personally feel it would be a tragedy to backtrack on the American Cancer Society guidelines," she said. The guidelines call for women to receive a baseline mammogram between ages 35 and 40, a mammogram every one to two years between 40 and 49 and an annual mammogram beginning at 50, she added.

"It would be wrong to deny women coverage for screening mammograms, particularly in light of these guidelines, which are part of a comprehensive and very reasonable approach to a preventive women's health care program," Dr. Sullivan continued. "I would like to encourage all of you who are involved in a government decision-making capacity to seriously consider this issue when questions [about mammography] arise."

Addressing the benefits of psychiatry for women, Dr. Schaff related stories of four patients she recently treated. She cited one case in which a patient with chronic medical problems finally confronted the abuse she'd been suffering for years at the hands of her live-in boyfriend. "This is a complicated case, but it came to my mind because it deals with the kinds of questions and issues we as women are all looking at now," Dr. Schaff said. "It is a great example of what women physicians and women legislators can [work on] together in terms of looking at the very real impact we can have on women's lives."

In her presentation, Dr. Orlowski described a study recently completed at Rush-Presbyterian-St. Luke's Medical

women in the peak years of their lives and result in high medical bills and lost productivity, she said. "It really is an inestimable amount of money. I think we're dealing with billions of dollars a year as far as migraines are concerned. And because people in the higher socioeconomic groups are those who tend to get help, the burden of illness is worse for those in the lower socioeconomic status."

Dr. Brubaker, who specializes in pelvic floor problems, discussed the need for early detection and the development of treatments for urinary incontinence. The condition afflicts an estimated 12 million

people, 80 percent of whom are women, she noted. "This is primarily a woman's disorder. We don't understand what causes it, and we're doing zero to detect it early and negative 100 to prevent it. We have the technology at our fingertips. What we want to do over the next 10 to 20 years is find out what problem is causing urinary incontinence and help women get the help they need so they can participate actively in their personal and professional lives."

During a question-and-answer period, discussion focused on how legislators could work more closely with physicians to connect policy development with

advances in medical science and research. Dr. Sullivan suggested the two groups collaborate to educate the public about the importance of preventive care. "The education aspect [of issues] is not legislated when you legislate other things," Dr. Sullivan explained. "On drinking and driving, for example, there was a tremendous public affairs effort [that coincided with legislation]. And it changed the values of society. That is the kind of thing that has to be done with preventive health care issues. If we could work together to educate people, we could have an impact." ■

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Center regarding the onset of renal failure in diabetics. The study revealed that an inexpensive medication already on the market can substantially slow the progression of renal disease. This is significant, Dr. Orlowski said, since dialysis costs about \$45,000 per patient each year. She also noted that Hispanic women account for the largest number of patients with diabetes-related kidney problems and that experts predict diabetes will be the No. 1 cause of renal failure by the year 2000.

"As we address the issue of health care reform, we have to remember that it is through this kind of publicly funded research and prevention that we can slow the progression of some end-stage diseases or find cures for some of the other problems we've discussed here," Dr. Orlowski said. "We can see that the complexion of medicine and the legislature has changed, and there's tremendous strength among us."

Dr. Olson covered migraine headaches, which she said are three times more common in women than men. Migraines most frequently afflict pre-menopausal

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PAGE 10

Illinois doctors to see lower Medicare payments

REIMBURSEMENT: Proposed changes in the RBRVS fee schedule hit some Illinois physicians hard. By Kathleen Furore

[CHICAGO] Many Illinois physicians who treat Medicare patients will receive lower-than-anticipated reimbursement beginning in 1995 if proposed refinements to the geographic practice cost indices recommended by the U.S. Health Care Financing Administration are implemented, according to an ISMS analysis of the proposed rule. Details of the changes were published in the June 24 Federal Register.

The total national funds earmarked for Medicare physician services will remain the same. But compared to doctors in other states, Illinois physicians in many areas will

receive significantly less in the future than they would have if the current GPCIs had remained in effect, the ISMS analysis said. For example, the revised GPCIs will result in a 7-percent to 10-percent cut in anticipated reimbursement for Peoria. Rock Island, Southeastern Illinois, Normal, Quincy, Southern Illinois and Rockford will be hit with reductions ranging from about 6 percent for Rockford to about 7 percent for Rock Island.

Payment cuts for services delivered in the counties surrounding Cook County will be
(Continued on page 6)

Survey shows support for doctors, caps

RESULTS: A new ISMS-commissioned poll highlights voters' attitudes about health care and tort reform. By Kathleen Furore

[CHICAGO] Eighty-two percent of Illinois voters want physicians to establish practice guidelines, even if it means paying more for health care than they would if insurers set quality standards, according to a June telephone survey of 800 registered Illinois voters. And 72 percent of respondents support caps on noneconomic damage awards in medical malpractice cases because of the negative impact of litigation on overall health care costs, the survey revealed. The survey, which was designed and analyzed for ISMS by the Coldwater Corp. of Ann Arbor, Mich., also showed that 46 percent of Illinois voters oppose President Clinton's reform proposal, and 64 percent believe the entire system is too complex to be reformed in 1994.

ISMS commissioned the poll to measure voters' satisfaction

with the health care system, attitudes about health care reform and the perceived credibility of information sources in the reform debate, said Ronald G. Welch, MD, chairman of the ISMS Board of Trustees. "This survey, which is a follow-up to one we did when health care reform was first introduced, is just another example of our intense interest in finding out what the public wants. The results are favorable for physicians. They show that as people become more familiar with what health care reform is all about and see what the various plans out there intend to do, they're less likely to jump on the bandwagon and say, 'I want to change things and don't care how much it costs.'

"Yet a significant majority are saying they'll pay more to have physicians control their
(Continued on page 15)

Blues' managed care plan begins precertification

UR: New requirements for preauthorization of elective procedures underscore importance of tracking and documentation. By Kathleen Furore

[CHICAGO] On June 27, Blue Cross and Blue Shield of Illinois began requiring physicians in its Managed Care Network Preferred plan to provide "some relevant clinical information" before it will precertify 11 designated nonemergency procedures, said Arnold Widen, MD, Blues vice president and medical director. The information will be used to evaluate the appropriateness of the procedures, and before precertification is given, primary care physicians must approve the procedures ordered by specialists, according to the Blues.

"We decided to introduce the appropriateness reviews in a small way initially for our approximately 110,000 MCNP participants and to start with high-frequency, high-cost, discretionary procedures," Dr. Widen said. "We'll probably introduce them into our PPO, which has more than 1 million patients, next."

The 11 procedures requiring clinical information for precer-

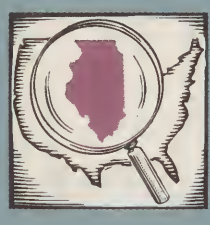
tification are brain CT scans and MRI; pelvic laparoscopy; hysterectomy; percutaneous transluminal coronary angioplasty; lumbar CT, MRI and myelography; repeat cesarean section; laminectomy, disc excision and fusion; knee and hip arthroscopy; breast cancer surgery and cholecystectomy.

The company that developed the clinical criteria being used to judge medical necessity and appropriateness received "tremendous input from physicians and took great pains to develop criteria sets compatible with practice guidelines," Dr. Widen said. Nevertheless, some physicians are concerned about implementing appropriateness reviews.

Precertification is a "tenuous process," said John Schneider, MD, ISMS Third District trustee and chairman of the Third Party Payment Processes Committee. "The primary care physician is required to give approval for a procedure, but
(Continued on page 9)

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Reform program
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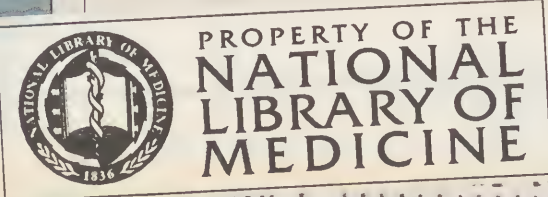
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David Hathcox

AS PART OF ISMS' Washington Presence program, Springfield family practitioner Jane Jackman, MD, ISMS Fifth District trustee, discusses health system reform with U.S. Rep. Richard Durbin (D-Springfield).



Federal government cracks down on fraud

INVESTIGATIONS: Physicians are implicated in a massive hospital referral kickback scheme. By Anna Chapman

[WASHINGTON] Following one of the most extensive multiagency investigations by the federal government, the U.S. Department of Justice announced June 29 that a corporation owning 60 psychiatric hospitals and substance abuse centers nationwide is required to pay \$379 million in criminal fines, civil damages and penalties for kickback schemes and fraud. The amount is the largest ever obtained in a health care case, according to the department. In addition, the corporation — National Medical Enterprises Inc., based in Santa Monica, Calif. — agreed to sell all its psychiatric hospitals and substance abuse businesses.

"This agreement, unprecedented in the health care arena, marks a new chapter in health care fraud enforcement," said June Gibbs Brown, inspector general for the U.S. Department of Health and Human Services. "The compliance plan serves to assure that NME possesses, in the future, the high degree of business integrity required of a provider participating in federally funded health care programs."

Charges against the NME hospitals included kickback payments to physicians, referral services and others, in exchange for patient referrals. Fraud committed in NME hospitals included bribes, billing for unnecessary treatment, multiple billing for the same treatment when multiple services were not provided, billing for services never provided and longer-than-necessary patient hospitalization, which depleted insurance

policies that had lifetime limits on mental health coverage.

"Bribes, unnecessary medical treatments and false billing harm all of us," said U.S. Attorney General Janet Reno, announcing NME's agreement to pay the fines and divest its psychiatric hospitals. Health care fraud is a major law enforcement priority, she noted, adding that an estimated 10 percent of health care funding is lost to fraud and abuse.

Although the case against NME has been settled, the government is continuing to investigate entities and individuals who were paid to refer business to NME, said HHS Regional Inspector General Michael Dyer. "Kickbacks are illegal both for the payer to pay and the receiver to receive," he said. Doctors and NME officers and employees are still under investigation, he said.

The prosecution of several cases related to fraud in NME hospitals is already under way, according to the Department of Justice. In December 1993, a physician medical director of an NME psychiatric hospital in San Antonio pleaded guilty to making false claims, theft of public money and forgery. He was sentenced to five months in prison and three years of supervised release. In addition, in May 1994, a federal grand jury returned a 19-count indictment against a Leavenworth, Kan., psychologist who allegedly received more than \$40,000 in bribes and kickbacks for referring patients to an NME hospital in Kansas City, Mo. ■

Condell Day Center wins governor's award

[LIBERTYVILLE] The Condell Day Center for Intergenerational Care recently won the Governor's Award for Unique Achievement from the Illinois Department on Aging and the state's area agencies on aging. Providing services for children from 6 weeks to 6 years old and adults over 55, the Libertyville center is the first institution in the Midwest specifically devoted to intergenerational care.

"The Condell Day Center is the perfect setting to build meaningful relationships that stretch across generations," said IDA Director Maralee Lindley. "The center gives children a solid foundation for learning and offers an alternative environment for older adults who are at risk of nursing home placement."

With more than 50 senior citizens and 130 children participating in the program, the center gives the young and old opportunities to interact with one another by providing a day care program that addresses the physical, emotional and social needs of children and older adults, the hospital said.

"We are extremely honored to be given this award," said Eugene Pritchard, president of Condell Medical Center. "The intergenerational program has brought a great deal of satisfaction to everyone associated with it." ■



Ron Ackerman

ISMS PRESIDENT Alan M. Roman, MD (left), was among the organizational representatives invited to participate in the bill-signing ceremony for Gov. Jim Edgar's Medicaid reform plan. The plan, which adopts a managed care approach for Medicaid, addresses ISMS priorities including a fee-for-service option using gatekeepers and an any willing provider provision. The reform plan also requires a formal explanation if physicians are terminated or excluded from participating in a Medicaid managed care plan. In addition, it includes provisions mandating broad physician input into all quality assurance mechanisms developed and implemented for the Medicaid program.

EHS and LGHS sign letter of intent to merge

[PARK RIDGE] Two Chicago-area health care organizations, EHS Health Care and Lutheran General HealthSystem, have approved a letter of intent to merge. If the merger is completed, the new organization would be one of the largest religiously sponsored health care networks in the country, with annual revenues projected at \$1.2 billion, according to a statement about the merger.

"Both EHS, which is related to the Unit-

ed Church of Christ, and LGHS, sponsored by the Evangelical Lutheran Church in America, have a history of community service to the medically disadvantaged as well as providing holistic care for the individual," said Richard Phillips, MD, LGHS board chairman. "The merger would bring together two strong, community-based organizations capable of offering a full continuum of health care services to the entire Chicago area."

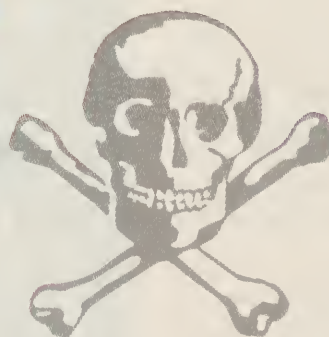
Together, EHS and LGHS would have 19,000 employees and 3,550 physicians and would be one of the largest and most accessible health networks in the Chicago area, with 177 care sites. The merger would also allow the two organizations to install the region's first area-wide computer network to simplify administrative systems.

Under the proposed terms of the merger, the United Church of Christ and the Evangelical Lutheran Church in America would be co-sponsors and would elect eight members and seven members, respectively, to the board of directors of the new organization. Richard Risk, EHS president and CEO, and Stephen Ummel, LGHS president and CEO, would be joint CEOs of the new corporation, with Risk serving as president and Ummel serving as chairman of the board.

According to Risk and Ummel, the merger must be approved by the sponsors of both organizations and the appropriate governmental bodies. The merger could go into effect as early as January 1995. ■

PHYSICIAN FACTS

Substances most frequently associated with poisonings



Source: 1992 Annual Report of the American Association of Poison Control Centers Toxic Exposure Surveillance System

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Reform program targets Chicago's Latino communities

COMMUNICATION: Physicians take reform messages to the airwaves. By Anna Chapman

[CHICAGO] Two Spanish-speaking physicians and a Chicago television station that broadcasts in Spanish teamed up recently to present health system reform issues to Chicago-area Latino residents. On June 26, WSNS-TV Channel 44's weekly interview program, "La Mesa Redonda," or "Roundtable," focused on key reform issues, which were presented by ISMS Third District trustee Aldo Pedroso, MD, and Eloy Moscoso, MD, a Chicago general surgeon who practices in a predominantly Latino community.

Drs. Pedroso and Moscoso said they wanted to participate in the program because Spanish-speaking Chicagoans may have missed out on reform discussions that are often held in English-speaking communities. In addition, reform will greatly affect Latinos, since many of them are uninsured, they said.

"The issue of insurance portability is especially pertinent to the Hispanic community," said Dr. Moscoso, whose patient base is 99 percent Latino. "There is more turnaround of jobs among Hispanics. It's not easy to get a job right away, and they suffer."

Nationwide, about 5 million Latinos are uninsured, Dr. Pedroso said. Although many of those individuals may be employed, they often work for small businesses that cannot afford to purchase insurance plans for employees, Dr. Pedroso explained. Those people are poor but do not qualify for state assistance, he added.

To prepare for the TV program, the doctors participated in ISMS' speaker training program. "The training was very helpful," Dr. Pedroso said. "It taught us how to be strong in our point so that people will believe what we're saying."

During the show, Drs. Pedroso and Moscoso discussed physicians' reform priorities. "We wanted to expose Hispanics to organized medicine in Illinois," Dr. Moscoso said. The physicians also encouraged viewers to contact their legislators and voice their concerns about health care reform, he noted.

"Our main interest is that everyone participate in this discussion," Dr. Pedroso added. "Senators and congresspeople should know the thinking of the whole population, whether they are minorities or not."

Specifically, the physicians described the role of organized medicine in reform discussions, Dr. Pedroso said. "We [said] that physicians were in favor of health care for everyone and benefits for everyone. We favor health insurance that is portable." In addition, they highlighted the importance of maintaining physician-patient relationships and freedom of choice for patients to select their doctors. "We said we are against a single-payer system because of rationing. And we are in favor of tort reform."

Dr. Moscoso added that during the tort reform discussion, he stressed that physicians do not oppose fair compensation for patients who are injured through medical malpractice. Instead, physicians are seeking to limit only noneconomic awards in malpractice suits, he explained.

Drs. Pedroso and Moscoso also

emphasized the need for patients to take more responsibility for their health care. "It's very important to make sure people take care of themselves before they get sick," Dr. Pedroso said. They recommended that individuals adopt healthy lifestyles and ensure that their children get the necessary immunizations.

Dr. Pedroso also urged viewers to write to CMS to obtain a copy of its position paper on health system reform,



which he translated into Spanish. "It was difficult to express the meaning [in Spanish]. If we translated directly, the meaning could be lost." For example, terms with no Spanish equivalent, such as "tort" and "portable," had to be fully explained.

The most difficult part of the program was covering the various issues in 30 minutes, Dr. Moscoso said. The physicians said they hope to be invited back

to the program in the fall to complete their discussion and provide new information about any reform measures that pass Congress this year.

"As [an ISMS] trustee, I have the responsibility to be in the forefront of this matter," Dr. Pedroso said. But he stressed that every physician should participate in reform discussions. "Whenever we have the opportunity to speak, we will." ■

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REPORT
FOR *Illinois Physicians*

ILLINOIS MEDICARE PART B

"NEW LOCAL MEDICAL COVERAGE POLICIES"

PALATOPHARYNGOPLASTY (CPT CODE 42145)

Effective August 1, 1994, this carrier will cover Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty) (CPT code 42145) when this procedure is performed for the following conditions, as classified in the ICD-9-CM (1994):

780.51	Insomnia with sleep apnea
780.53	Hypersomnia with sleep apnea
780.57	Other and unspecified sleep apnea

FERRITIN (CPT CODE 82728)

The serum ferritin level correlates closely with total-body iron stores. A low ferritin level is diagnostic of iron deficiency. Although a high ferritin level indicates the degree of iron overload, the level can underestimate iron stores in some patients with early hemochromatosis.

Effective August 1, 1994, Ferritin (CPT code 82728) will be considered a medically necessary test only for the following conditions, as classified in the ICD-9-CM (1994):

275.0	Disorders of iron metabolism
280.0	Iron deficiency anemia secondary to blood loss (chronic)
280.1	Iron deficiency anemia secondary to inadequate dietary iron intake
280.8	Other unspecified iron deficiency anemias
280.9	Iron deficiency anemia, unspecified
281.9	Unspecified deficiency anemia
285.0	Sideroblastic anemia
285.1	Acute posthemorrhagic anemia
285.9	Anemia, unspecified
571.5	Cirrhosis of liver without mention of alcohol
571.8	Other chronic nonalcoholic liver disease
571.9	Unspecified chronic liver disease without mention of alcohol
585	Chronic renal failure

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EDITORIAL

Take advantage of member services

Managed care has had a cataclysmic effect on health care. Think of the upheaval that has emanated from that one concept: the alphabet soup of structural options for providers, practice guidelines, new liability problems, precertification, economic credentialing, plan contracts. The list gets longer every day.

Organized medicine is working hard to help you do more than just survive in our changing profession; it is working to help you thrive. ISMS and the AMA are lobbying on your behalf in Washington. As part of ISMS' Washington Presence program, some members met with lawmakers in July to discuss physicians' and patients' concerns about health system reform. The meetings were extremely productive, with legislators taking the time to really listen to medicine's viewpoint. The timing was especially critical, since several federal bills are under consideration, and the debate over certain provisions of those bills is more heated than ever.

To help members stay on top of legal issues related to managed care, ISMS is offering the Lawyer Referral Network. Members can tap into the expertise of one of many participating attorneys by calling (800) MD-ASIST. An ISMS legal staff member determines each caller's specific needs and refers him or her to an attorney. Whether you need help with

managed care, licensure, contracts, medical staff issues, Medicare and Medicaid, taxes or issues related to fraud and abuse, the network will match you with the right lawyer. All participating attorneys have been screened and selected by ISMS, and all offer their services at a discounted rate.

ISMS is developing another member benefit as well – consultant referral services. As part of its research, the Society invites members to provide information about their positive experiences with managed care consultants. To recommend consultants, you may call (800) MD-ASIST.

In addition, the Society is keeping you up-to-date on reform and managed care topics through *Illinois Medicine*. This issue contains stories about an ISMS survey that reveals Illinois voters' opinions about health system reform and health care delivery, a new precertification program by Blue Cross and Blue Shield of Illinois and potential pitfalls in managed care contracts. The publication's continuing managed care coverage includes news developments and practice management issues. If you have ideas for managed care stories or want to respond to a published story, please contact the *Illinois Medicine* staff.

To provide the information and services you want, ISMS needs your input.

PRESIDENT'S LETTER

Laughter is the best medicine

Alan M. Roman, MD



Having fun or just feeling happy has a measurable effect on our health and well-being and on those around us.

“Justin gave me a sticker,” my daughter, Lindsay, gleefully exclaimed while I was engrossed in phone conversation. “Because he loves you,” I answered somewhat reflexively, continuing to focus on the important matter at hand. A few moments later, Lindsay abruptly reappeared at my study door and the scene was repeated, though for the life of me I could not figure out how Justin had gotten the stickers from their hiding place on the upper shelf of the bookcase. When I finished the phone conversation, Lindsay again appeared, and this time, I asked to look at her treasure. She stuck out her chest, and on a self-adhesive file-folder label, which Lindsay displayed so proudly, Justin had written, “Lindsay is a dope!”

No doubt, laughter is good for us; laughter is healthy. Preschoolers laugh almost 450 times per day, adults slightly more than a dozen. Whether a giggle or a guffaw, a chuckle or a chortle, a hee-hee or a haw-haw, it is a sensation of feeling good all over. Mirth is an expression of the spirit and the heart and the body joined together. (I laughed until my sides split.) Laughter can add more years to your life than sit-ups and the StairMaster combined. Having fun or just feeling happy has a measurable effect on our health and well-being and on those around us. A sense of humor has been linked with longevity.

Laughter, however, is much more. A person's character is defined partly by that which brings him or her to good humor. People with a good sense of humor are a scarce commodity, not because they make a joke out of life, but because they simply recognize the ones that are already there.

Consider the value of a sense of humor and the high regard with which it is held. It is the one thing that no one admits to not having. It can relieve stress and dispel negative thoughts. Humor puts

life into perspective and helps us to gain control. Humor can make us laugh for seconds, but then think for hours. It is a way to overcome the unexpected and tolerate the unpleasant. Everyone understands and responds to a smile. Smiles are wondrous things. They can be given out for eternity, and yet there is always one left for yourself.

A sense of humor is what makes you laugh at something that would make you mad if it happened to you. Everything is funnier when it happens to someone else. Beyond the appreciation of absurdly incongruous elements, humor is an expression of the freedom of the human spirit. It is a means to deal with the melange of life's moments – the humdrum, the unexpected, the unreasonable and the perverse – many of these outside our control. Cheerfulness, while an intangible, has a concrete positive impact on our communication, our relationships and our productivity. Humor is our front-line defense against life's rough edges.

Life does not cease to be serious when people laugh. But laughter does relieve tension, heal the pain of disappointment and strengthen the spirit for the daunting tasks that always lie ahead. Considering the strains that physicians are under day and night, without laughter, life would be painful indeed.

Recognize and accept, if you will, that there are for physicians difficult times yet ahead. To be positioned for success requires preparation, introspection and a sense of humor. Resolve to create in yourself today an increased appreciation for the humor that surrounds you in everyday life and measure your life by the litany of well-told jokes, pleasing anecdotes and abundant laughter. Learn not only to laugh but to laugh at yourself. Put a smile on your face and laughter in your heart. After all, the world is a wonderful place, and everyone should enjoy it once in a while.

GUEST EDITORIAL

Physician input critical to successful PHOs

By Thomas Gorey, JD



LETTERS

Trauma centers revisited

I read with interest the July 15 issue of *Illinois Medicine*. In particular, I was struck by an article ["EHS Good Samaritan gains Level I trauma status"] noting the Level I trauma status of EHS Good Samaritan Hospital. I found it particularly interesting that the hospital officials are quoted as saying that Good Samaritan is the only Level I trauma center between Maywood and Iowa City, Iowa.

While I realize that we may be somewhat smaller and less obvious than some of the Chicago suburbs, Rockford itself is the home of two Level I trauma centers. Both St. Anthony Medical Center and Rockford Memorial Hospital hold Level I trauma designations for the state of Illinois and carry out their role of providing excellent care. I do not want anyone from the state to have the misconception that Level I trauma care can be provided only east of Maywood or west of Iowa City.

— Charles J. Wright, MD
Rockford

Following standard of care

The article "Finger-pointing damages defense" ["Case in Point"] in the July 15 issue of *Illinois Medicine* is well-written and accurately states how finger-pointing among physician defendants makes the defense of medical malpractice cases very difficult. The description of the first case, concerning a miscommunication between a radiologist and a referring Ob/Gyn regarding a patient's mammogram, deserves further comment.

It is technically true that under 1987 conditions, the radiologist met the applicable standard of care by simply sending a written report of an abnormal mammogram to the physician's office, and a phone call to the referring physician was unnecessary, since the findings at the time were not life-threatening. But it should be emphasized that the standards in 1994 are quite different.

In 1990, the American College of Radiology published its *Standards for the Performance of Screening Mammography*, which states: "All reports in the high-probability category should be communicated to the referring physician or his designated representative by telephone, by certified mail, or communicated in such a manner that receipt of the report is assured and documented." Any deviation from that standard by a radiologist after 1990 is virtually indefensible in a court of law. Good patient care and good risk management mandate physicians' careful adherence to these standards.

— Leonard Berlin, MD
Chicago

Managed care article cited

Your recent article "Primary care physicians are joining ranks," which appeared in the June 3 issue, was very well-written. Health Spring's president and medical director, Kaveh Safavi, MD, was impressed with the author's ability to so accurately capture his main message. Thank you for choosing to include this informative and interesting article in *Illinois Medicine*.

— Kim Tassi,
Health Spring Medical Group
Bloomington



ON BEHALF of ISMS' Committee on CME Accreditation, chairman John Jurica, MD (left), accepts the President's Award for CME Excellence from representatives of the Illinois Alliance for Continuing Medical Education. The committee was honored for the innovative services it has developed for CME sponsors accredited by ISMS.

As the health care market continues moving toward a managed-care-based system, physicians are expressing an interest in – and in some cases even developing – models of physician integration and physician-hospital integration, including physician hospital organizations. These integrated systems are proliferating because of physicians' and hospitals' desire to use provider-controlled organizational strategies to respond to the changes in the health care environment.

In October 1993, ISMS, the AMA, the Indiana State Medical Association and the Michigan State Medical Society conducted a national study of PHOs and the physician organizations associated with them.

One of the study's main goals was to provide answers to questions like the following: Are PHOs a viable concept? Can PHOs provide an organizational mechanism to meet the needs of patients, physicians, hospitals, businesses and payers? Can PHOs be effective in a competitive managed care environment? And, most important, what have been the experiences of PO and PHO participants?

As change accelerates in health care, it will be more critical for organized medicine to provide physicians with timely information about changes in the organization, delivery and financing of health care services, as well as potential strategies physicians can adopt. This study demonstrates the commitment of ISMS and the other sponsoring medical societies to ready their members for change.

Although not all physicians are equally comfortable with managed care and some may be apprehensive about PHOs, the PHO prototype is one model that warrants physicians' consideration as part of their long-range strategic planning. The study did not seek to endorse PHOs; instead, it aimed to create an objective source of information to answer physician questions about PHOs and help doctors make informed decisions related to their goals and circumstances.

What was learned from the study? Among other findings, it highlighted and confirmed the critical importance of POs in the development and operation of PHOs. Participating in a PO structure first enables physicians to build consensus and set long-term goals in preparation for ongoing negotiation with hospital administrators about PHO issues.

The study revealed that another key ingredient in developing

successful POs and PHOs is the leadership of dedicated and respected physicians. The desire to become active in managed care is only one component of a successful physician-driven managed care strategy. Physicians must also be willing to devote the necessary time and energy to the task.

A well-organized and focused group of physicians, with talented and motivated leaders, represents half of the PHO equation. The other half is a hospital administration and board that are committed to the PHO concept and are willing to share control and decision-making within a joint venture framework, the study showed.

Although the level of trust between physicians and hospital administrators typically increases as they begin working together in a PHO, there must be some trust at the outset. Unfortunately, because that is lacking in some cases, the PHO model may not represent a realistic and viable strategy for all physicians and hospitals.

Other key elements of successful PHOs include an effective medical management program, a solid management information system, adequate capitalization and staffing, and a governance structure that recognizes the legitimate interests of primary care and specialist physicians and the hospital administration.

Are PHOs a silver bullet? As most PHO representatives will admit, such organizations have advantages and drawbacks. However, this study demonstrates that if PHOs are properly organized, capitalized, governed and administered, they can be effective in a variety of markets, including competitive managed care settings.

Depending on a physician's specialty, age, goals, preferred practice style, financial resources, level of risk-tolerance and geographic location, other models may be more or less attractive and effective in achieving the physician's goals than a PHO, the study showed. If physicians pursue a PHO,

however, they may be more successful if they learn from participants in other PHOs, including those in this study.

ISMS and the other medical societies should be commended for this study and for helping fill the information void regarding PHOs.

As a membership benefit, ISMS is providing the PHO study free to member physicians. To order the study, call ISMS' health care finance division at (312) 782-1654 or (800) 782-ISMS, ext. 1131.



Gorey, president of Policy Planning Associates in Crystal Lake, served as the project consultant for the PHO study.

Medicare payments

(Continued from page 1)

less than 1 percent. In contrast, Medicare reimbursement in Connecticut, Rhode Island, Maine, New Hampshire, South Carolina, Wisconsin, New York, Florida, Texas and Arizona will be higher as a result of hikes in GPCIs for those states, according to the ISMS analysis.

"I doubt if more than a handful of physicians understand how the GPCIs are calculated," said John Schneider, MD, an ISMS Third District trustee and chairman of the Third Party Payment Processes Committee. "What we're told is that [HCFA] ran some numbers

through a computer program and – guess what – Illinois physicians' median hourly income, cost of clerical help, office rent and malpractice costs haven't gone up as much as they have in other places. The problem is that what's run out of the computer program in Washington doesn't bear up to reality. It's not borne out in terms of what physicians are seeing in their own practices."

According to a HCFA spokesperson, GPCIs – which reflect expenses related to physician work, practice overhead and malpractice liability expenses – measure the costs of operating a practice in each Medicare fee area compared with the national average. He said HCFA

used 1980 census data to establish the original GPCIs for 1992-94 but is now using 1990 census data for the work GPCI, 1990 census data and 1994 U.S. Department of Housing and Urban Development data for the practice GPCI, and expanded 1990-92 data for the malpractice GPCI.

Dr. Schneider questioned the appropriateness of some of that data, however. "HCFA used residential rather than commercial rental rates for the practice expense GPCI. The old concept of a doctor practicing in a home office is a rarity now. In larger areas, most doctors are in group practices and pay rents for spaces in commercial buildings."

The AMA is also expressing concern about HCFA's methodology for calculating the new GPCIs. "We're pleased the GPCIs have been updated, but [we're] concerned about the proxy data that's been used," an AMA staffer explained. "Instead of using HUD data on residential rental rates, we propose they survey how much physicians are paying for rent per square foot. We also think they should find out things like how much physicians are paying nurses on an hourly basis. That kind of information would be more credible and accurate."

In addition, the AMA is questioning the proxy data HCFA used for the work GPCI, since it is based on census data for professionals other than physicians, he noted. "Our basic concern is that the data [aren't] really reflective of physician income and expenses," he said. An ISMS analyst, however, pointed out that using "better data" won't necessarily raise the GPCIs and associated fees for Illinois physicians, since the total funds available for physician services must remain the

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*The problem is that
what's run out of the
computer program in
Washington doesn't bear
up to reality.*

same and any and all changes made will be budget neutral.

Medicare fees under RBRVS are determined by multiplying the GPCIs by the relative value units of a particular service, then multiplying the sum by a national dollar conversion factor, which increases annually to adjust for inflation, the Medicare volume performance standards and other factors, the HCFA spokesperson said.

An ISMS analyst explained that fees in Illinois may not actually decrease as much as the GPCI cuts seem to indicate, because of two additional factors. First, each Jan. 1, the fee schedule conversion factors are increased. "Whereas the GPCI cuts will reduce fees, the conversion factor changes will increase them," he explained. Second, fees for some services – particularly evaluation and management services – are expected to increase as a result of the RBRVS phase-in, which will be complete in 1996. He noted the phase-in will moderate the impact of the GPCI cuts for those services. Reimbursement for other areas, such as surgical services, is decreasing as a result of the phase-in, he added. "The GPCI cuts will compound those reductions in surgical services," he said.

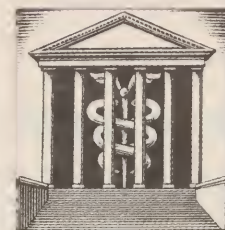
HCFA has also recommended other Medicare payment policy changes, the analyst said. They include payment for care plan oversight for Medicare home health care patients in certain circumstances and increased payments for multiple surgeries.

According to the ISMS analyst and the AMA staffer, both organizations are reviewing the proposed rules and will be submitting comments to HCFA by the Aug. 23 deadline. "Once our in-depth analysis is complete, ISMS will vigorously pursue redress with HCFA, the ISMS analyst said. ■

*Managed care
mandates pose
documentation
challenges*

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ISMIE Update



*Malpractice
Roundup*

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Survey reveals voter concern about frivolous lawsuits

LIABILITY: Respondents said the current tort system is not working well and needs immediate reform.

By Anna Chapman

[CHICAGO] Ninety percent of Illinois voters believe that lawsuits without merit are a serious problem, according to a new poll commissioned by the Illinois Civil Justice League, a coalition of business groups, associations and municipalities. The survey also revealed that many respondents think frivolous lawsuits have resulted in higher medical costs, higher insurance premiums and higher taxes, said league president Ed Murnane during a July 25 press conference in Chicago. The telephone survey of 600 registered voters was conducted the last week of June by Voter/Consumer Research of Bethesda, Md.

"These results support what we have been saying all along—that lawsuit abuse is a serious problem in Illinois and that it must be stopped," Murnane said. Since no tort reform legislation, such as caps on noneconomic damages in medical malpractice suits, emerged from the 1994 spring legislative session,

the league is encouraging the public to petition lawmakers to take action, Murnane noted. The survey was a first step in gauging the public's concern and understanding of liability reform, he said.

*Sixty-four percent
of the respondents
said they would
not vote for a
candidate who
received campaign
contributions
from trial lawyers.*

"This issue does not split down party lines, gender lines or socioeconomic lines," said Jan van Lohuizen, president of

the survey firm. "There is concern among people from all walks of life and political backgrounds that Illinois' present liability system is not working well and needs immediate reform. The survey shows Illinois [voters] mostly blame personal injury lawyers for the problems."

According to the survey results, 34 percent of respondents said they are most concerned that frivolous lawsuits increase medical costs, and 21 percent said they fear higher insurance premiums related to liability.

Seventy-five percent of respondents said the current system has problems and should be improved. Respondents were also asked whether they agreed with a series of statements describing liability problems. Seventy-six percent agreed that too many lawsuits are filed, 82 percent said too many frivolous lawsuits are filed, 75 percent said too many

people take unfair advantage of the legal system and 61 percent said too many people are being sued who don't deserve it.

When asked whether they would consider voting for a candidate who is endorsed by personal injury lawyers, 58 percent said no. And 64 percent of the respondents said they would not vote for a candidate who received campaign contributions from trial attorneys, the survey showed.

"One remarkable result of this survey is that more than half of Illinois [voters] are afraid that they will be a victim of a lawsuit," Murnane said. "We are constantly reminded on TV and radio and in newspapers that personal injury lawyers are out there soliciting business. We shouldn't have to worry that the next meritless claim they file could be against one of us."

In addition to the statewide survey, the league conducted four smaller surveys to "test

local geographic areas against the statewide results," Murnane explained. The additional surveys were conducted in the Rockford and Quincy areas, as well as the suburbs in northern and western Cook County and southern Lake County. "In each case, the numbers tracked very well" with the statewide results, he said.

The league has also launched a series of television advertisements in the Rockford, Quincy and Chicago areas, Murnane said, adding that plans are to broaden the campaign across the state by mid-October. The ads, which were shown at the press conference, feature real lawsuits that could be considered frivolous. One such ad portrays a man who fell out of a tree and sued the maker of a snack food he had eaten, claiming it caused his fall. The ads suggest that many people hire a "certain kind of plaintiff lawyer who looks for someone to sue—maybe sue you."

The ads also provide a toll-free telephone number for individuals to call and order an action kit, which includes materials to help people get involved in changing the system by contacting their legislators, Murnane said. To obtain an action kit, physicians may call (800) 757-3247. Physicians who have more detailed questions may call the league at (312) 263-1633. ■

Coalition continues fight for tort reform

EDUCATION: Members of the Illinois Civil Justice League discuss the costs related to liability suits. By Anna Chapman

[ELK GROVE VILLAGE] Tort reform will likely be a significant campaign issue in the fall elections, according to Ed Murnane, president of the Illinois Civil Justice League and moderator of a July 12 forum the league held for the Greater O'Hare Association of Industry and Commerce. Although meaningful tort reform was not enacted in the state legislature this year, pressure from league member organizations helped elevate the issue to the forefront of debate during the legislature's spring session, Murnane said before the forum.

"We're working to make tort

reform a major issue in the fall campaigns," Murnane said. He added that there is considerably more statewide interest in tort reform now than when the league was formed last year. "We've had articles and guest editorials and letters to the editor in more than 65 newspapers in Illinois within the last month and a half. People are getting the message. Our effort between now and the end of the year will be to continue to raise that level of public awareness."

Among the league's members are nonprofit organizations like ISMS, entrepreneurs, small and large businesses, local govern-

ments and associations. Since December 1993, the league has conducted forums around the state to educate the public about the high cost of frivolous lawsuits.

"One of the objectives of the forums is to be able to show the public that the liability problem in Illinois is not just a problem facing the business community," Murnane explained. "The whole issue of tort reform during the recent session of the Illinois General Assembly was portrayed as business reforms in exchange for riverboat gambling. I know that the medical community doesn't think that tort reform is just a



During a recent tort reform forum, Alfred Clementi, MD (right), chairman of the ISMIS Board of Directors, explains how the increasing number of lawsuits are driving up costs and forcing doctors to practice defensively.

business issue. What we're trying to do through these forums is let people know that it affects us in a lot of different ways. Everybody ought to be concerned

about reform, not just people involved with the Illinois Manufacturers Association or the state Chamber of Commerce."

(Continued on page 8)

MALPRACTICE ROUNDUP

Physicians win suit against malpractice carrier

In what has been called a landmark decision, the Colorado Supreme Court last fall unanimously upheld a 1989 trial court verdict in favor of 105 physicians who sued their malpractice insurer for breach of contract, bad faith and fraud. The case against PHICO Insurance Co., a liability carrier owned by the Hospital Association of Pennsylvania, was reported in the April 25 issue of *Medical Economics*.

In the early 1980s, PHICO, which provided malpractice coverage for about 25 percent of Colorado's physicians, aggressively marketed its claims-made policies, promising to serve the state "for the long haul," according to the article. At the same time, the company assured physicians that it would cap the cost of tail coverage at a fixed percentage of the annual mature-rate premium to "eliminate all of the unknowns." But even as it was telling physicians it intended to remain in the Colorado market, PHICO was planning to stop insuring individual physicians because that market was unprofitable, the *Medical Economics* story said.

PHICO stopped writing new policies in 1984. It also imposed rate hikes of up to 60 percent per year on existing policies, demanded that premiums be paid in lump sums and raised the cap on tail-coverage premiums by 22 percent. Court records later referred to those actions as deliberate attempts to drive off existing customers even though independent agents and PHICO employees told physicians facing renewal dates that the company intended to continue covering Colorado doctors. The article noted that by mid-1986, PHICO had pulled out of the market, forcing existing policyholders to purchase expensive tail policies, find new insurers or go without malpractice coverage.

In June 1986, the Hartford Fire Insurance Co. compounded the situation by failing to renew the policies of more than 1,000 physicians, leaving the state medical society's COPIC Insurance Co. as the only major carrier writing malpractice insurance in the state. Because COPIC was barraged with applications, its surplus was inadequate, and it had to force new policyholders to pay an extra year's premium.

Fighting back against the Pennsylvania carrier, each of the 105 doctors involved contributed \$1,000 to pay a retainer for a law firm and filed suit against PHICO. Among other charges, the physicians claimed the insurer breached its contract by raising the tail premium after it had promised a fixed cost.

The trial court found in favor of the physicians, ruling that PHICO knowingly made false representations to the physicians and created a sense of crisis and panic to justify premium increases. On appeal, PHICO argued that the claims-made policies in question were one-year contracts and that the physicians agreed to any changes when they renewed. The appellate court agreed and reversed the trial court verdict. But the Colorado Supreme Court overturned the appellate court ruling, stating that the insurer "was bound by its promise to provide tail coverage at the rate initially contracted for." The high court further held that PHICO "concealed its intention and actively misled the doctors to their detriment."

To date, PHICO has decided not to appeal the most recent ruling, but the court has not yet entered a decision regarding damages to be awarded, the article said. ■

Lack of communication leads to unnecessary surgery

A recent Florida case in which a woman's breast was unnecessarily removed underscored the importance of communication and follow-up. According to a case summary in the May 1994 issue of the *Medical Liability Monitor*, a 41-year-old patient was scheduled for a mastectomy after a pathologist mistakenly read a tissue sample from a breast biopsy as malignant. Although another pathologist discovered the error two weeks before the scheduled surgery and notified the patient's physician, the patient and the surgeon scheduled to perform the mastectomy were not notified. The patient underwent the surgery as scheduled, and her breast was removed.

After learning of the error, the patient sued the four physicians involved. A Jacksonville jury found the physicians proportionately negligent and awarded the plaintiff \$2.7 million, the case summary said. ■

Coalition

(Continued from page 7)

FORUM PARTICIPANTS reported a wide range of liability problems and urged fairness in liability laws. Jack Boecher of Raco Industrial Corp., a small business that purchases and resells used machinery, said his firm may be held accountable for accidents involving equipment it sold years ago. Boecher said for six of the past 10 years, his company has been "unable to buy products liability insurance. It's unsettling when one lawsuit without insurance puts you out of business."

Representing ISMS, Alfred Clementi,

MD, an ISMS Third District trustee and chairman of the ISMIS Board of Directors, addressed the problem of frivolous medical malpractice suits in Illinois. Physicians have been working to achieve tort reform since 1975, when many medical malpractice insurers left the state, Dr. Clementi explained. "In 1985, we did pass some reforms that were very helpful to us, but unfortunately trial attorneys were able to get around some of the reforms. Since then, there has been a considerable escalation of suits, resulting in significant cost."

On average, the cost associated with a closed medical malpractice suit has almost doubled since 1985, Dr. Clementi

said. "It has gone from an average \$184,000 for a case closed with payment to \$350,000. Fault is not necessarily the reason an attorney becomes involved in a case. What they consider a good case is a case that has a lot of damage" involving a young person, a family or a financial loss, he added.

Dr. Clementi said many suits are no more than "fishing expeditions" in which attorneys try to find someone to blame. He noted that the large number of suits against physicians have forced doctors to practice medicine defensively, ordering tests that may not be necessary so that they are protected if a suit is filed later.

To help rectify the situation, Dr. Clementi said physicians are calling for a \$250,000 cap on noneconomic losses in medical malpractice suits. "Pain and suffering does exist, there's no question about that. Noneconomic worth is something we think ought to be compensated to some degree. We feel that \$250,000 is very generous."

Also affected by out-of-control lawsuits are local municipalities and non-profit organizations. Marc Hummel, the village manager of Hanover Park, described liability problems affecting police departments and city governments.

Hummel noted that suits have been prompted by officers' use of deadly force. In addition, high-speed chases have resulted in liability suits, he said. If a suspected felon causes an accident while being pursued by police, the city is often held responsible for the damages, he explained.

Hummel also described a case in which a jury awarded several million dollars to an unlicensed, drunken motorcyclist who was injured in an accident. The jury awarded the damages based on its conclusion that a traffic sign was improperly placed, he said. "It's the responsibility of the taxing agency to do its very best. If that's not good enough, should there be a multi-million dollar verdict?"

Marcia Barber, executive director of the DuPage County Girl Scouts, said an increasing amount of her workload "revolves around liability issues." Each year, she reviews and signs thousands of hold-harmless agreements and parental consent forms, which are required by roller rinks, riding stables, bus contractors and other entities involved in Girl Scout activities, Barber said. "You can imagine the time involved. Our attorneys and insurance companies ask to see every parent waiver." ■

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Blues' plan

(Continued from page 1)

the primary gatekeeper is not the most knowledgeable source as to the specialist's diagnosis and proposed treatment. It seems unnecessary to require the primary care physician's approval if the recommended procedure meets the criteria established by MCNP to appraise the procedure."

In addition, Dr. Schneider expressed concern about the difference between the development of appropriateness criteria and that of practice guidelines. "Appropriateness criteria should be developed and processed in the same fashion as practice guidelines, with adequate input from the local specialist doctors affected by the criteria," he noted. Dr. Widen said the criteria will be modified based on input from practicing physicians and Blues' experience.

Dr. Schneider said he is also worried that the new appropriateness reviews represent a move toward increased precertification procedures and away from the development and implementation of practice guidelines as agreed upon by ISMS and the Blues in early 1994. In the past the Blues has indicated that it wanted to move away from precertification review and toward the development of practice guidelines and physician profiling, he said. With guidelines and profiling, the focus is on specific physicians rather than all physicians in the network, Dr. Schneider added. In response, Dr. Widen said the Blues hopes to step up its physician profiling efforts in the next two years and exempt many profiled physicians from the review process.

Physicians participating in the MCNP plan have received forms for precertification summaries, which can be sent to the Blues to expedite the precertification procedure, said Prentiss Taylor, MD, Blues associate medical director. "We want to minimize hassles to the practicing physician. Office managers, nurses or any designated staff member can communicate the [clinical] information verbally or by fax, so it's not necessary to take up the physician's precious time. One of our nurses will call back and convey the approval or nonapproval of the proposed procedure."

Dr. Taylor said preauthorization requests should be initiated by the physician who is ordering the procedure. The Blues will accept specialists' verbal assurances that they've received approvals from primary care providers, he said. All denials will automatically be referred to a Blues physician reviewer, who will discuss the decision with the attending physician, Dr. Widen added. "If the attending physician still disagrees with the decision, he can ask for a review by another consulting physician in the same field."

THE APPROPRIATENESS REVIEWS are just one example of changes that are creating new tracking and documentation challenges for physicians practicing in managed care environments, according to health care consultants experienced in practice evaluation and practice guideline development. "Even if the plan says physicians don't need to, it's important for physicians or someone on their staffs to have a record of any conversations and communication with the managed care entities," said Steven Baker, MD, senior physician consultant with Milliman & Robertson Inc. in Milwaukee. "No system is foolproof. There may be

an agreement or decision made to get preauthorization, and someone [at the managed care organization] in good faith could lose or misplace the record of agreement. The best advice is if there's any interaction, write it down or have your staff do so."

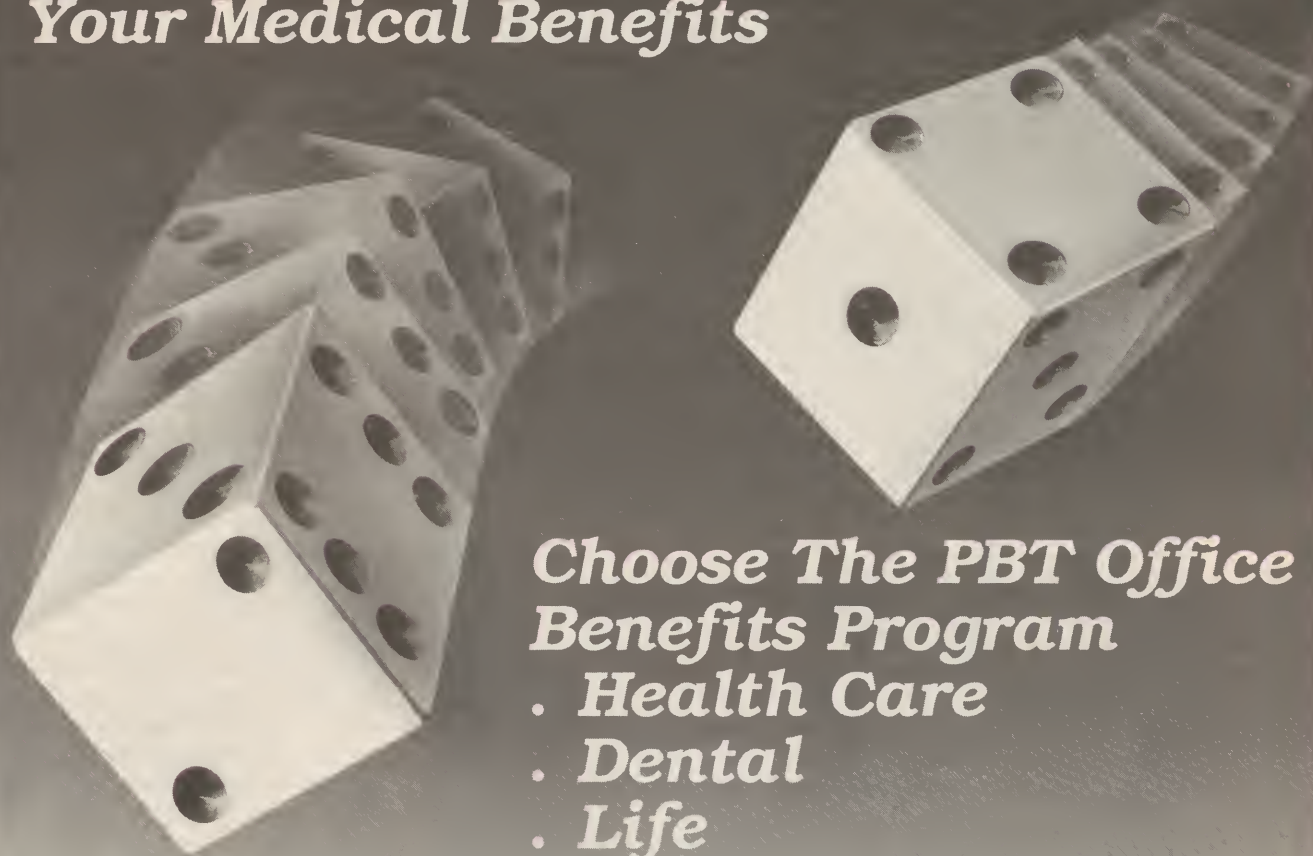
The documentation should include the name of the person authorizing or denying the treatment and an explanation of that decision, said Jimmy Dale Love, a partner in Chicago's Medical Group Development Services.

Documenting communication between referring primary care providers and specialists is equally important,

Love noted. "In many managed care plans, a specialist needs a formal referral from a primary care physician. The primary care doctor should document the referral and put a copy of the specialist's report in the patient's clinical chart. The specialist should document any calls made to, and get a copy of the records from, the primary care physician. And everything should be dated, because legally speaking the specialist takes over [responsibility for] the patient's care upon referral." Love added that formal documentation should also exist for referral back to the primary care physician.

The consultants stressed that physicians should establish office procedures that ensure timely and accurate documentation and tracking. "With all the interaction that's occurring between office staffs and managed care organizations, setting up a system of tracking and documentation is a real challenge for some offices, especially small ones," Dr. Baker said. "That's why many physicians are moving into bigger, integrated systems. There's always a trade-off between office overhead and the expertise needed. But physicians should have a practice manager who has a clinical and business sense." ■

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SECOND OF TWO PARTS

Cover your bases with managed care contracts

With good preparation, physicians can win at the contract negotiation game.

BY KATHLEEN FURORE

When physicians review managed care agreements, they should specifically consider provisions covering proposed payment and reimbursement, utilization review, confidentiality of patient records and appeals, according to attorneys participating in ISMS' Lawyer Referral Network. Reimbursement terms in managed care contracts are more important than ever for physicians, since the current health care delivery system is moving toward risk-based payment and reimbursement methods, the attorneys said. So before signing any managed care agreement, doctors should understand exactly what risks they're assuming and how their compensation will be determined, they said.

"Capitation is an effective way for managed care entities to shift financial risk to physicians," said Judee Gallagher, a Chicago attorney in private practice and an ISMS network participant. "And no matter what the capitation structure, the extent of risk depends on the specific provisions in your contract."

Among the provisions doctors should scrutinize are those regarding covered services, eligibility and stop-loss insurance, Gallagher said. "The contract should specifically identify all the services you're financially responsible for providing and list those excluded from capitation. If the services aren't listed, you won't know the extent of your financial responsibility. For example, some contracts define covered services as 'those services covered according to the subscription certificate,' but that certificate may not specifically list the services."

Gallagher advised physicians to analyze the covered services "one by one" and carve out high-cost, high-frequency procedures. "Physicians could carve out organ transplants or say they'll diagnose but not treat infertility as part of the capitation agreement. Payments for those procedures could be made on a fee-

for-service basis, or the physician could refer patients to another provider," she explained. She added that doctors should find out whether they'll be able to provide all services for which they're financially responsible and who will deliver the services that they cannot provide. Physicians should also consider how member eligibility is determined, since compensation depends on the number of patients assigned, and ask whether the plan provides stop-loss insurance, which protects providers from unlimited losses associated with catastrophic cases, Gallagher said.

RISK POOLS ARE another area physicians must analyze, said ISMS network participants Anne M. Murphy, of Chicago's Vedder, Price, Kaufman & Kammholz, and Thomas J. Reed, a private practice lawyer in Chicago. "Usually, an incentive or bonus pool is established to reward physicians for practicing within specified utilization review parameters – not using 'too many' specialists or not hospitalizing 'too many' patients," Reed explained. "But providers should find out how discretionary the compensation is and what it's based on. I've talked to physicians who've been in plans for quite a while and don't understand why they are or aren't being compensated. They say



Patrick Whelan

SECOND OF TWO PARTS

there's no rhyme or reason to the payments."

Reed added that physicians should identify which factors trigger their entitlement to compensation and who is included in the pool, since the percentage of each doctor's payment varies according to the number of participants. "The situation often is that if you practice less costly medicine [than others in the pool], you'll get a better return. But even though a formula looks good, the population you're treating may be sick or elderly. And yuppie patients are a piece of cake to care for cost-effectively compared to elderly patients."

Physicians should also examine the risk-withhold mechanism to determine how and when the money is released to members of the pool, Murphy advised. "A physician may be reimbursed based on performance criteria at the end of the year, or the third-party payer may use the withhold pool to ensure that potential losses are covered. Providers entering contracts should be aware of the potential financial liabilities involved with a withhold pool."

UTILIZATION REVIEW is fundamental to the concept of true managed care and should be thoroughly covered in contract negotiations, the network attorneys said. UR typically addresses protocols; prior approval for tests, referrals and hospital admissions; concurrent review; length of stay guidelines; and discharge planning, Gallagher said.

Many physicians have faced problems with utilization review systems, Gallagher noted. "The systems may not be prompt. Your staff may spend hours on the phone to obtain precertification for a hospital admission. The referral list may not contain the variety of specialists conveniently located for your patients. The system may not 'certify' all the steps necessary for a particular course of treatment. The procedures may be altered without your consent. And if the system includes penalties, the guidelines for their imposition may be so vague that you're unclear about your obligations."

Some of those problems can be avoided by carefully evaluating the organization's UR program, keeping standard of care issues in mind and insisting that all protocols, rules, procedures and criteria to be followed are part of the written contract, Gallagher said. She also recommended that physicians try to include a provision in their contracts that requires providers' consent for any changes made to the UR plan.

It's also important to ensure that physicians are involved in formulating an organization's UR policies, Reed said. "Find out who will sit on committees and formulate and implement UR. You don't want it solely administrated by a company not using MDs."

Reed advised physicians to ensure that any contract they sign offers an opportunity to explain utilization patterns. "A provider might have high utilization on mammograms because his or her patient population is ripe for that kind of testing. Physicians should know how a plan's utilization review guidelines will take that information into account."

MAINTAINING THE CONFIDENTIALITY of plan patients' records is a concern from ethical and risk management standpoints, so physicians should make sure that any contract they sign addresses confidentiality, according to Reed and Gallagher. "It is appropriate for managed care entities to want records of plan patients," Reed said. "But contracts should have strong provisions to protect patients' confidentiality," such as limits on disclosure, he added. "If you were talking about medically necessary procedures, for example, information in the records should be used only

(Continued on page 12)

Don't drop the ball

The following questions – compiled by Judee Gallagher, a Chicago attorney and participant in the ISMS Lawyer Referral Network – address a few issues physicians should consider before signing a contract.

INSURANCE AND LIABILITY

1. Does the contract contain an indemnification and hold-harmless clause holding you responsible for costs incurred for lawsuits filed and judgments entered against the plan?
2. Is the organization required to maintain adequate professional liability insurance and provide you with a certificate of insurance?
3. Does the contract make you responsible for the organization's utilization review system?
4. Does the contract make you solely responsible for all medical care?
5. If the contract requires you to participate on committees, does it also require the organization to provide insurance for these activities?

STANDARD OF CARE AND UTILIZATION REVIEW

1. Does the contract require you to perform services outside the scope of your normal practice?
2. Is the organization required to contract with an adequate number and variety of competent specialists?
3. Are the UR protocols, rules, procedures and criteria you must follow specified in the contract? Do changes require your consent?
4. Who develops the UR program? What are their qualifications? Do physicians have input into developing or adopting the program? Are physician reviewers in the same specialty as the treating physicians who are being reviewed?
5. Is there a prompt, fair and neutral written procedure to appeal review decisions and contest arbitrary rules?
6. Does the contract exclude prior authorizations in medical emergencies?

PAYMENT AND REIMBURSEMENT IN CAPITATED AGREEMENTS

1. What services are you responsible for under capitated contracts?
2. What services are covered? Does the contract identify all services you're financially responsible for providing and list services excluded from capitation?
3. Can you provide all of those services directly? If not, who will, and how much will it cost you?
4. Can the organization add services without your consent?
5. Is your financial exposure for the cost of referral services unlimited?
6. How is your eligibility determined? Remember, compensation depends on the number of members assigned to you.

PAYMENT IN MODIFIED FEE-FOR-SERVICE AGREEMENTS

1. What services are covered? How are covered services authorized?
2. How are your fees determined?
3. Is the organization required to pay your fees within a specific number of days after receiving claims?
4. If a risk-sharing arrangement is involved, what is the extent of your risk? Can the organization increase the percentage of your fees that are at risk without your consent? Is your risk limited to the withheld percentage, or are you also at risk for deficits in other pools? Are you at risk for care rendered out of the network?

TERMINATION

1. Can contractual provisions be changed without your consent? If so, can you terminate the contract with minimum notice if you object to the changes?
2. Can you terminate the contract only on the annual renewal date, or is termination effective any time after you give the required notice?
3. Under what conditions can the organization immediately terminate the contract?
4. Does the contract infringe on physician-patient communications upon termination?

■

Managed care

(Continued from page 11)

to determine medical necessity and shouldn't be disclosed to a third party without the patient's consent."

Managed care organizations should bear the responsibility for obtaining such consent, Reed and Gallagher advised. "Some managed care entities try to make obtaining a release of medical records part of the provider's contractual obligation," Gallagher warned. "I generally suggest having that kind of clause deleted because if there's a dispute regarding confidentiality, physicians can be drawn into it if they've obtained the consent."

The better way is to negotiate to make the plan responsible."

Gallagher also recommended that physicians not sign a contract that makes obtaining patient consent forms a condition of payment. "We generally like to have the managed care entities do as much of the bureaucratic work as possible," Reed added. "Then they can supply the [patient-signed] releases to the physician's office."

PRESERVING THE RIGHT TO APPEAL decisions made by managed care organizations about such issues as payment, termination with cause and determination of medical necessity is another critical aspect

of contract negotiations, the lawyers said. "Appeals are important in two respects," Reed explained. "One, when a managed care entity denies permission to do a certain procedure, it doesn't mean it won't create a situation of possible negligence for the physician, so it's important on the defensive side. And two, if a physician is terminated from a plan, it can have serious economic ramifications, since it affects access to patients."

Reed advised physicians to negotiate an appeals process that provides sufficient notice to physicians of any action being taken and reveals what he called the "particulars of what the problem really is. If it's a question on a certain patient, you would want the patient's charts identified, so when it comes time for a hearing, you have the opportunity to effectively present your case."

Gallagher added that it's essential for physicians to understand the relationship between the appeals process and their financial responsibility. "You want to be aware of what, if any, financial penalty is attached if you provide services contrary to the medical necessity determination of a plan. Some contracts say physicians can provide care that has been ruled unnecessary if they get OKs from the patients and the patients say they'll pay. And in one plan I know of, there's a provision to bring in a third party to determine medical necessity regarding hospitalization. But that plan also says if the third party decides hospitalization is unnecessary and the physician doesn't abide by that decision, the physician will have to pay the hospital costs."

Although an appeals process can be indispensable for resolving many disputes, the attorneys agreed that such due process protections won't remedy problems that arise from termination-without-cause actions. According to Murphy, physicians could challenge exclusion or termination without cause from a plan on grounds of antitrust or any-willing-provider claims. But traditionally it has been difficult to prevail on those challenges, she said. "Physicians should realize that though there are legal principles to rely on if they want to appeal, any time they file a legal challenge, it is an expensive and time-consuming process. They should understand that antitrust or any-willing-provider claims are difficult and recognize there'll be significant legal hurdles to overcome."

"I don't know of any physician who has prevailed in appealing a termination-without-cause decision," Gallagher agreed. "If the contracting parties have agreed to termination without cause, the courts are reluctant to step in." Reed suggested negotiating into contracts a grievance procedure that allows for physician input in termination-without-cause incidents. "It's paradoxical. But if there is a process whereby a physician could be heard, he or she might be able to persuade the plan not to invoke [the right to terminate]."

Physicians seeking the services of an attorney who specializes in health care contract issues can receive an immediate referral through ISMS' Lawyer Referral Network. To access the network, call the ISMS managed care action line at (800) MD-ASIST. ■

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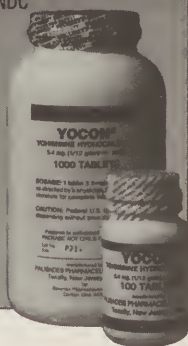
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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ISMS survey

(Continued from page 1)

destiny," he continued. "The more educated they become, the more faith they have in their doctors rather than in politicians and insurance companies."

That support of physicians is reflected in the survey's finding that 83 percent of Illinois voters rated their doctors as believable sources of information regarding reform issues. "[What's] particularly important is that in spite of all the talk about reform – you see it on the front pages every day – people have the highest amount of trust in what their physicians say about health care reform," said Mary Lukens, vice president of Coldwater Corp. "That reinforces the importance of the medical society's grass-roots efforts to communicate with patients."

Lukens also cited voters' positive attitudes about tort reform. "The people of Illinois have become even more supportive of caps and understand that tort reform can be a significant way to control the overall costs of health care."

Other findings were that voters are satisfied with the quality and availability of health care but are concerned about the cost of care and health insurance. Specifically, the poll showed that 79 percent of respondents expressed satisfaction with the availability of health care

In spite of all the talk about reform, people have the highest amount of trust in what their physicians say about health care reform.

services, 80 percent with the quality of health care, 81 percent with the amount of time it takes to get in to see a doctor and with the ability to see a specialist when needed, and 89 percent with their relationship with their physician. However, 55 percent of the voters polled said they are dissatisfied with the price of health care and health insurance.

In addition, a majority of Illinois voters – 54 percent – said they are not willing to pay additional taxes to fund a national health care system, the survey showed.

"We know the public wants some kind of health care reform," Dr. Welch said. "[The public] thinks there are too many people who are uninsured and lack access to health care, and they feel they're paying too much for care and want to control costs."

"But based on this survey, the people of Illinois are becoming more familiar with what it is going to take to reform the system and don't want to rush in and change it for the worse," he added. "They'd rather do it slowly and do it right. That shows that our efforts are working and that it is very important for physicians to keep educating the public about health care reform." ■

Chamber releases survey on health benefits

[CHICAGO] Employee health coverage is offered by 95 percent of all members of the Illinois State Chamber of Commerce, according to the Illinois Chamber's 1994 Health Benefit Survey. Of the 5 percent of employers who do not offer coverage, 87 percent employ fewer than 100 workers.

The survey, which was sent to more than 5,000 Illinois Chamber members earlier this year, focused on employer-sponsored health coverage, plan costs and design, and reactions to legislative

proposals for health system reform.

According to survey results, 44 percent of employers who do not offer any health coverage cited cost as the primary reason. Of those respondents, 97 percent employ fewer than 500 people, and 71 percent employ fewer than 25.

Nearly half the responses from member firms indicated that plan costs increased less than 10 percent from 1992 through 1993. However, small employers – those with fewer than 100 employees – were more likely to experience larger rate increases: Forty-two percent had increases of more than 10 percent.

Survey results showed that 47 percent of employers offered PPOs in 1994, as

opposed to 25 percent in 1991. One-half of small employers currently offer PPOs.

Since the Illinois Chamber surveyed its members on health benefits in 1991, opposition to employer mandates has increased from 53 percent to 58 percent. At 72 percent, opposition to employer mandates was greatest for employers with more than 100 workers.

In addition, the Illinois Chamber of Commerce reported that the survey responses indicated employers' unwillingness to support regional alliances. More than three-fourths of the respondents said they opposed alliances covering employers with fewer than 5,000 employees. ■



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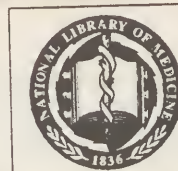


Physicians give the public a closer look at medicine

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Illinois Medicine

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PAGE 2

The art of marketing a medical practice

PROMOTION: Physicians should communicate their strengths. By Kathleen Furore

[CHICAGO] In today's increasingly competitive managed-care-driven marketplace, physicians must become businesspeople, and part of their business should be marketing their practice. That's the mes-

plans have multiple listings of preferred providers. Choices may be narrowed by managed care, but the ability to choose still exists. What's new is that physicians have begun to pay more attention to the importance of marketing."

Marketing involves more than printing slick pamphlets and placing expensive ads, according to health care consultants. "Marketing is not [only] brochures and direct mail. It's a way of approaching your business," said Terry Rynne, president of Evanston-based Rynne Marketing, a health care marketing firm.

"Physicians have to be strategic in their marketing approach," added Ruthie Harris, executive vice president of Physician Strategies 2000, a health care management company in Franklin, Ohio. "They must know the strengths and weaknesses of their practices before marketing and promoting themselves to anyone." She said assessing such variables as practice style, outcome data

(Continued on page 8)

MANAGED CARE

sage from health care consultants, who said marketing can help doctors keep their current patients and attract new ones, establish rapport with referring primary care providers and win spots in managed care plans.

"Physicians have to remember that patients, referring doctors, hospital nurses, referral services, pharmacists and managed care plans can still choose providers," said Karen Zupko, president of the Chicago-based practice management consulting firm Karen Zupko & Associates. "We may be moving toward a managed care system, but it's not without choices. Patients aren't being herded. Gatekeepers can choose where to send patients, and most

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John McNulty

CHICAGO CUBS' right fielder Sammy Sosa (center) promotes the importance of childhood vaccinations Aug. 6 as Rosa Subero, MD (left), updates 5-year-old Gabriela Rodriguez's immunizations.

Federal reform debate focuses on antitrust

By Kathleen Furore

Committee adopts
antitrust amendment

Hospital groups and
physicians face off

[WASHINGTON] On Aug. 2, the House Judiciary Committee adopted an amendment that would provide antitrust relief for physicians and was designed for addition to House Majority Leader Richard Gephardt's (D-Mo.) health reform bill. The passage of the amendment, sponsored by Rep. Charles Canady (R-Fla.), was especially significant because it reversed an earlier committee vote against a Canady-proposed antitrust amendment and because committee chairman Jack Brooks (D-Texas) vehemently opposed any antitrust reforms, according to James Todd, MD, AMA executive vice president.

The committee's action constituted preliminary "recognition by Congress that physicians are being placed at a

(Continued on page 14)

[CHICAGO] The American Hospital Association is making its presence known in the reform debate by opposing the creation of statutory antitrust relief for physicians such as the reforms proposed in President Clinton's reform plan and in the Health Care Quality Improvements Act of 1993.

"While we have identified antitrust concerns that need to be addressed, the AHA does not view broad statutory exemptions from the antitrust laws as necessary or appropriate for development of integrated delivery systems," said Rick Pollack, AHA executive vice president, in a July 29 letter to the AMA. "We continue to encourage hospitals and physicians to collaborate. But the Health Care Quality Improve-

(Continued on page 14)

ISMS BEHIND THE SCENES

ISMS SEEKS CHANGES IN MEDICARE RBRVS GPCI CUTS

ISMS is actively seeking modifications to proposed changes in Medicare RBRVS that would significantly reduce geographic practice cost indices for Illinois physicians next year, said ISMS Board Chairman Ronald G. Welch, MD. The U.S. Health Care Financing Administration used what many physicians believe to be inappropriate data to alter the GPCIs, Dr. Welch said. GPCIs reflect local expenses related to physician work, practice overhead and malpractice liability.

"ISMS is pursuing an action plan to attempt to ameliorate the impact of these new GPCIs on Illinois physicians and to uncover any potential errors or biases in the data that would disproportionately skew Illinois' results," Dr. Welch noted in an Aug. 4 memorandum to ISMS officers and trustees.

Without a significant restructuring of the proposed rule, Illinois physicians will receive less-than-expected increases in reimbursement for some Medicare services, while doctors in other states will see increases for delivering those same services, according to an ISMS analyst. Because the government's changes in the GPCIs are budget neutral, they will not affect the total national funds earmarked for physician services. That's why the gains calculated for physicians in other states necessitate the decreases for physicians in other areas, particularly in Downstate Illinois communities, the analyst said.

In response, ISMS has launched a multifaceted action plan. As *Illinois Medicine* went to press, ISMS representatives were

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Photo courtesy of Daily Herald/Vincent Pertierra

ISMS SECOND VICE PRESIDENT David Littman, MD (right), a Highland Park internist, examines a patient at the Lake County Health Department's year-old outpatient clinic. More than 50 area residents with AIDS obtain local access to primary care physicians at the clinic.

Direct mail campaign promotes mammograms

[CHICAGO] A brochure describing the benefits of screening mammograms for women in their 40s was recently sent to 11,000 Illinois primary care physicians as part of a new American Cancer Society direct mail campaign. According to the ACS, "The Case For Screening Mammography in Women Ages 40-49" discusses the society's disagreement with National Cancer Institute recommendations and its support of mammography screening for women in that age group.

"Given the number of women diagnosed with breast cancer in their 40s, we believe it is extremely important to continue mammography screening for women ages 40 to 49," said Stephen Sener, MD, president of the Illinois Division of the American Cancer Society. "We are committed to educating physicians – along with legislators, insurers, women

and the men who love them – about the benefits of mammography for women in this age group." Dr. Sener added that the organization is concerned that current debate about the benefits of mammograms for women in their 40s will discourage women from having the tests, which could be lifesaving procedures.

About 29,000 of the 183,000 breast cancer cases diagnosed in the United States in 1993 were in women ages 40 to 49, according to the ACS. That same year, some 32,000 cases were diagnosed in women ages 50 to 59 – women for whom regular mammography screening is recommended without question, the ACS said. The organization also noted that almost one-fourth of all breast cancer deaths occur in women who are diagnosed in their 40s.

For more information about the mammography campaign or to order additional brochures for your patients, contact the ACS at (800) ACS-2345. ■

Association offers diabetes support group

[CHICAGO] Adult diabetics now have a forum in which to discuss the stress and emotional issues related to diabetes. The Northern Illinois Affiliate Inc. of the American Diabetes Association has established a new adult support group to enable individuals to share common frustrations and challenges as they cope daily with the disease.

The group meetings are not meant to provide formal diabetes education or be a source of medical advice, the association said. Sessions are held at 5:30 p.m. on the first Tuesday of every month in suite 1202 of the ADA's offices at 6 N. Michigan Ave. in Chicago. Participation is free. For more information, call (312) 346-1805. ■

Correction

In the story "Survey reveals voter concern about frivolous lawsuits," published in the Aug. 12 issue, an incorrect telephone number was listed for the Illinois Civil Justice League. The correct number is (312) 263-0817. ■

Health clinic joins SIU program

DOWNSTATE CARE: Rural health initiative enables clinic to continue serving area residents. By Kathleen Furore

[LEBANON] Through an affiliation with the Southern Illinois University School of Medicine's family practice residency training program, the Lebanon Family Practice Center will be able to continue providing health care to area residents. The clinic, previously operated by now-retired physician Delbert Harris, MD, was jeopardized when Dr. Harris was unable to recruit a physician to take over his 35-year-old practice, said an SIU spokesperson. The affiliation between the clinic and SIU is one in a series of Rural Health Initiative Partnerships being developed by the university, the spokesperson said.

"I believe this is an example of the cooperative relationships that are needed as part of the health care scene in Downstate Illinois," said Carl Getto, MD, dean and provost of the SIU medical school. "The problems of manpower, reimbursement levels in rural areas, malpractice and general economic decline usually add up to more than [what] one physician or a single community can deal with. We're pleased we can be part of the solution, and we will continue to work on others."

Initially, the clinic will be funded through the partnership program, which

the General Assembly passed in 1990 and funded in 1993 to improve the delivery of health care services in Illinois' rural and designated-shortage areas, the spokesperson said. Dr. Harris donated the building housing the clinic to St. Elizabeth's Hospital in Belleville, and the hospital will continue to maintain the premises, according to SIU.

Paul Reger, MD, who completed his residency at SIU and was recruited by the university to staff the clinic full time, said the clinic has been well-received by area residents. "The response has been favorable. We've seen a lot of new patients who formerly had gone to Dr. Harris but then went to Belleville and other areas when he cut back his hours [before retiring]."

Dr. Reger's staff at the center includes a registered nurse, a medical assistant, a billing and insurance manager and a receptionist. He said the clinic is located in a designated underserved area of the state and attracts predominantly geriatric patients, although many of the new patients have been children in need of back-to-school physicals. Dr. Reger said he hopes the clinic will be able to begin offering obstetrics and prenatal care services, which are difficult to find in the area. ■

Swedish Covenant joins Northwestern network

[CHICAGO] Swedish Covenant Hospital in Chicago became the sixth member of the Northwestern Healthcare Network on July 1. The relationship "will further strengthen Swedish Covenant's mission as a nonprofit, low-cost, quality health care system," said Edward Cucci, Swedish Covenant presi-

dent and CEO.

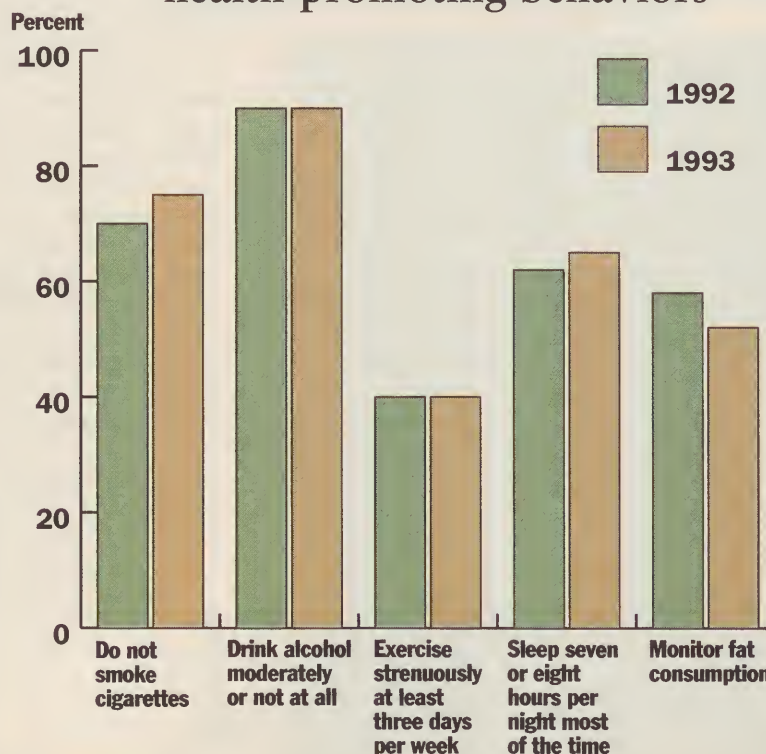
The affiliation between the 340-bed community hospital and the Northwestern network reflects the continuing evolution in Chicago's health care delivery system, which is characterized by shifts toward managed care, according to hospital and network officials. "Health care is undergoing tremendous change," Cucci said. "In response, hospitals are forming regional health care systems to better coordinate health services, improve quality and reduce costs."

Bruce Spivey, network president and CEO, said Swedish Covenant is an ideal partner, with an "unmatched track record" of community-based primary care. "Our affiliation with Swedish Covenant is a major step toward further solidifying NHN's market position with the leading hospitals and physicians in the Chicago area, providing the highest quality care at the most competitive cost."

The network includes 3,300 physicians and will now operate 2,017 beds, officials said. Other network members are Children's Memorial Medical Center, Evanston Hospital, Glenbrook Hospital, Highland Park Hospital and Northwestern Memorial Hospital. Northwestern University Medical School is also linked to the network. ■

PHYSICIAN FACTS

Two-year comparison of health-promoting behaviors



Source: The Prevention Index, 1994

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Program highlights hepatitis treatments

PUBLIC HEALTH: Prevention efforts center on screenings and immunization. By Anna Chapman

[CHICAGO] Chicago-area experts and a representative from the U.S. Centers for Disease Control and Prevention discussed the prevention and management of hepatitis during a July program for physicians and other health care workers. The seminar was sponsored by the Chicago Department of Health and the American Liver Foundation.

Alfred Baker, MD, a professor of medicine at the University of Chicago, presented an overview of current hepatitis epidemiology. "The alphabet of hepatitis is increasing," Dr. Baker said, noting that in addition to the well-known A, B and C strains, scientists have now identified hepatitis D and E.

The A strain is common and easily transmitted, he said. "In the United States, about one-half of the population that reaches age 50 has been infected by hepatitis A."

Worldwide, about 250 million people are infected with hepatitis B, he said. Serum containing hepatitis B can be diluted 100-fold and still cause infection, Dr. Baker noted. Transmission can occur through close family contact, sexual contact or a needle stick.

Preventing the spread of the viruses that cause chronic infection among all ages is one of the national objectives of the CDC, said Frank Mahoney, MD, head of its Hepatitis Prevention Unit. The CDC's action plan includes screening all pregnant women and vaccinating all newborns, adolescents and adults at high risk, such as health care workers. He stressed that just giving an infant the first of three inoculations is insufficient; health care providers should help ensure that newborns complete HBV vaccinations as scheduled. "The first dose at birth is just the first step. They must complete the series."

Dr. Mahoney said technology and research are alleviating some physician concerns about the HBV vaccine — including the number of shots, the cost and the efficacy. Combination vaccines will soon be available to reduce the number of immunizations, he noted. And the ratio between the cost and the years of life saved "compares favorably." In addition, scientists believe the vaccine offers significant long-term protection from hepatitis infection, Dr. Mahoney said. Even though the antibodies that develop from the HBV vaccine tend to diminish over time, studies have shown that no immunized individual has developed clinical disease or chronic infection, he added.

"Essentially all adolescents are at risk and should be vaccinated," Dr. Mahoney said. For this age group, the vaccine must be delivered prior to the onset of high-risk behavior, he added. Teen-agers in middle schools are a good target for immunizations, and the CDC has set up several demonstration projects in schools around the country, he said.

Universal screening for pregnant women has yet to become a reality, Dr. Mahoney noted. He said he believes state laws and hospital policies mandating screening would greatly improve the likelihood that women would be checked for the virus.

Interferon, a natural body chemical used for treating viral infections, is the most effective treatment for hepatitis A,

B and C, according to Donald Jensen, MD, director of clinical hepatology at Rush-Presbyterian-St. Luke's Medical Center. Other antiviral therapies are "quite experimental," he said, noting that the only other treatment is a liver transplant, which is sometimes used in chronic cases.

Although initial treatment with interferon could result in increased liver damage, it generally "shuts down viral repli-

cation," Dr. Jensen said. The liver damage is caused by the body's stepped-up efforts to fight the infection. Only about 40 percent of patients respond to therapy. In addition, once interferon treatment is ended, patients often relapse, he said. The more active the liver disease, the greater the patient's potential responsiveness to treatment, he explained.

Interferon is also associated with several side effects, Dr. Jensen noted. It can affect

bone marrow levels and cause flu-like symptoms, such as fever, headaches, malaise and fatigue. Those symptoms usually diminish with each dose. He recommended treating patients with interferon in the evening, instructing them to take acetaminophen one to two hours before treatment and then allowing them to sleep through the symptoms.

Cost is a drawback of interferon treatment, Dr. Jensen said, noting that therapy for one patient with hepatitis B can run as much as \$125 a week or \$3,000 for the typical 24-week treatment period. "It makes more sense to prevent the disease," he said. "How many doses can we give before we bankrupt the country?" ■



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REPORT for Illinois Physicians

AVOIDABLE HOSPITAL DAYS - IMPROVING EFFICIENCY

Appropriate efficiency in the use of hospital days is a major objective of every managed care organization's utilization review program. Attention to this important area has yielded impressive results, as evidenced by the continued downward trend in hospital bed days seen in HMO's — the rate of hospital days, per 1000 members per year, now is well below 300 in most plans, having fallen over 30% in the last five years. Indeed, the mechanisms developed by managed care plans for review of hospitalization days have now been extended to other health insurance products, including traditional indemnity health insurance, with a resulting significant drop in hospital utilization overall in the United States.

Despite this drop, there is evidence that opportunities for further reductions still exist. At Blue Cross Blue Shield of Illinois (BCBSI), the Medical Department continually reviews its experience with hospital utilization in managed care networks, in order to identify issues that lead to medically unnecessary hospital days. The size of these networks, and the large volume of reviewed cases, provides a substantial database upon which significant observations can be made, and has allowed the Medical Department to group these issues into general categories.

Presented below is a summary of the most important factors that lead to unnecessary hospital days, as observed by BCBSI in the past year, listed in order of descending frequency. It is the Medical Department's hope that sharing this information with Illinois physicians will provide them with some understanding of how BCBSI views hospital utilization review, and will help physicians re-evaluate their own practices. Hopefully, this will result in fewer inquiries from BCBSI's utilization department to physicians.

- ◆ Failure to develop an overall treatment strategy and discharge plan within 24 hours of admission and to document it clearly on the chart.
- ◆ Performance of tests in the hospital that could be done on an outpatient basis (especially GI evaluations).
- ◆ Admission the day before elective surgery.
- ◆ Failure to call necessary consultants early enough, or failure to see the patient promptly.
- ◆ Not considering alternate care arrangements, such as SNF, home care or hospice, early enough in the hospital stay.
- ◆ Poor coordination of ordered diagnostic tests, or consultant recommendations, causing schedule delays.
- ◆ Failure to change parenteral therapy to oral therapy at the earliest appropriate time.
- ◆ Failure to transfer patient out of ICU/CCU at the earliest appropriate opportunity.
- ◆ Rounding by attending physicians too late in day to effect earlier discharges.
- ◆ Reluctance of covering physicians to discharge on weekends; no weekend discharge planning.
- ◆ Not reviewing patients' social situations, and failing to orient family members early enough regarding post-discharge care needs.
- ◆ Non-availability of hospital services on weekends, such as certain diagnostic tests (avoid as possible by anticipatory scheduling).

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EDITORIAL

Trial lawyers move to undermine tort reforms

The trial lawyers are back with a vengeance. They have been lobbying for so-called "medical malpractice reforms" that would constitute a blanket federal pre-emption of state tort reform and would specifically jeopardize the reforms ISMS fought for and won in 1985. That pre-emption was recently unveiled in the Senate by Majority Leader George Mitchell (D-Maine) and in the House by Judiciary Committee Chairman Jack Brooks (D-Texas) as part of health system reform bills.

This year, for the first time, caps of \$250,000 and \$350,000 were included in two draft bills at the federal level. Unfortunately, neither cap advanced. But inclusion of caps in federal legislation is still significant and demonstrates some support.

Support for the pre-emption provisions is impossible to understand, given that the "average U.S. doctor spends \$15,000 per year in malpractice insurance, and premiums for anesthesiology and obstetrics can go as high as \$200,000 per year," according to a Harvard study quoted in the Aug. 4 *Roll Call*. (The complete *Roll Call* story is reprinted on the facing page.) The story also states that the rate at which

physicians are sued has increased tenfold in the past 30 years, and the average award in winning lawsuits has increased from \$40,000 to nearly \$150,000 over the past 20 years, factoring in inflation. Reforms to control defensive medicine could save \$4 billion per year, according to another study cited in the story, conducted by the consulting firm Lewin-VHI.

Clearly, we have the facts on our side. And we have Illinois voters on our side. A recent ISMS survey showed that 72 percent of respondents support caps on noneconomic damages because of the negative impact of litigation on overall health care costs. In addition, an Illinois Civil Justice League survey revealed that 90 percent of Illinois voters believe that lawsuits without merit are a serious problem and 64 percent said they would not vote for a candidate who received campaign contributions from trial attorneys.

The trial lawyers are single-minded in trying to block attempts at true medical malpractice reform. We must be even more determined to preserve current tort reforms and to pass a cap that cannot be superseded by federal legislation. If health system reform sacrificed tort reform, it would be a tragedy.

PRESIDENT'S LETTER

Just beginning

Alan M. Roman, MD



Each phase of life tricks me into believing that is how it will always be.

Today, as I do every day, I called my dad. I gently reminded him it was my brother, Ron's, birthday. Dad has become more forgetful with age and has perhaps lost track of many of the milestones we shared while I was growing up.

How vividly I remember sledding on the Midway Plaisance, enjoying rainbow cones on hot summer nights and playing catch in the driveway. There was nothing my dad did not know or could not do. His presence made everything OK.

Later on, he sent me through college and medical school. And although he seemed a little out of date, he always kept in touch to see how things were going and whether he could be of help. He had a genuine concern for my growth and development. Although he scarcely let on, he knew me better than I knew myself. His advice helped conquer every obstacle. He always felt that my needs were as important as his own. He taught me that you can give without loving, but you can't love without giving.

Now in this — my presidential — year, when I am eager to share so much, I poignantly realize how much Dad has changed through the years. You never know how right your father was, the saying goes, until you have children old enough to recognize how wrong you are. And when I reflect on all the years, I appreciate how smart he was and the lessons I've learned from him.

Each phase of life tricks me into believing that is how it will always be. However, there is no magic dust to keep my children just the size they are now, to enable me to brush their teeth and carry them to bed. Nothing lasts forever. Today's moments are just that — today's — and tomorrow or next week, they will be your memories.

The weight of my experiences has given me a set of values I now must pass on to my children. My experiences make me want to be a better father and to remember more clearly my children's milestones.

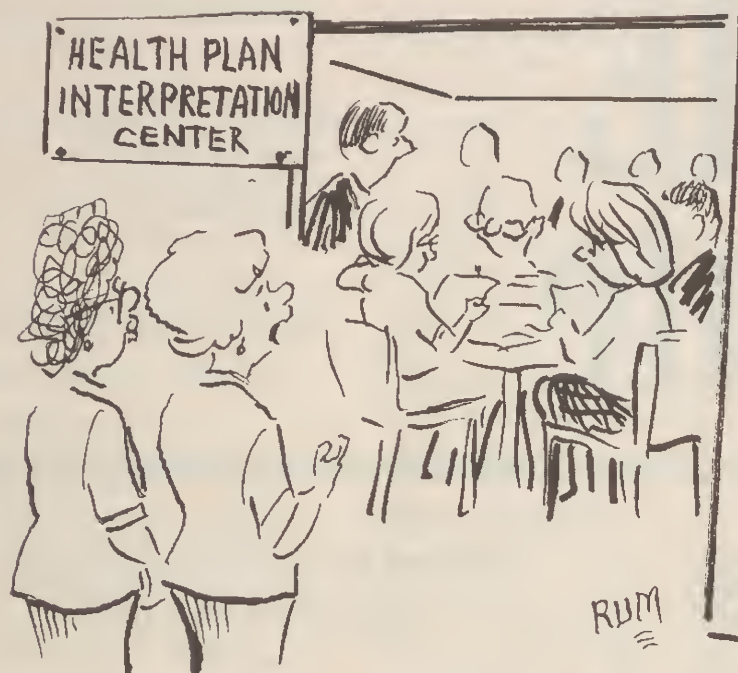
My dad has given me a wonderful journey through life. What he has done is part of what I have become. I will always cherish what Dad did right and forgive him for the few, but inevitable, honest mistakes that came in raising me and my brother.

Just as he held my hand when necessary to keep me from stumbling, he now looks to me for advice. I miss the time when I innocently trusted Dad to carry me through life, protecting me from harm. With his oversight diminishing, I feel more alone and more responsible for my family's well-being.

I have friends without parents, and when they share their memories, I thank God my parents are still included in my family circle of laughter and good times. Dad has been with me since my trip began, and I can't imagine how life would be without him. Still, it is inevitable that parents die, and so, too, do their children. Too soon we grow old, and too late we grow wise. One day we are children, soon adolescents, then spouses, parents, and up the ladder of life. We should never close the door on where we've been and what we've learned.

Sure, Dad is getting older, a price he pays for the privileges of age. So I stopped this day for a moment in time to remind Dad of my brother's birthday. Yes, I thought of Dad and tried to imagine it was like old times again. And I also took a mental picture of my family. How nice that Dad is becoming free of the past and the worries of the future. How nice that my children are enjoying the stuff of childhood. I also realized how little time it is taking for my children to grow up.

I recognize now that I might end up like my father. I certainly could do far worse. What he has taught me, I will teach my son. And so the circle of life continues. My mortality should be my blessing. I will recognize Dad in the depth of my son's eyes and know there are no final moments.



"It finally happened. We've got more health plan interpreters than doctors and nurses!"

LETTERS

Abortion linked to execution

It is absolutely amazing to me how political correctness has infiltrated the editorial page of *Illinois Medicine*. Really, have you ever read or have you any idea what the Hippocratic Oath that you so proudly quote with the words *primum non nocere* means? Can you explain to me why these words are fine and acceptable for opposing participation in executions and not for opposing participation in the killing of 1.5 million babies every year in our great society, with the blessing and approval of the medical profession?

Please be consistent in your editorials. I oppose physician participation in executions, and I oppose physician participation in abortions. Why do you approve of one and condemn the other? Political correctness, I suppose.

Editorials like this one make me realize that the Hippocratic Oath is the oath of hypocrites and make me laugh at your interpretation.

Wake up and do not contradict yourself. Oaths and words mean something, and they are not to be taken lightly depending on where the political wind blows at the time.

— Roberto S. Puentes, MD
Peoria Heights

in executions is fundamentally inconsistent with the healing role of the medical profession."

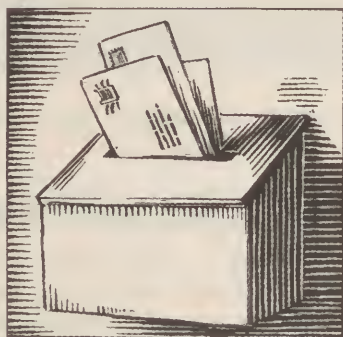
I would hope to see in the future a similar editorial taking a very strong position on the issue of physician participation in abortions. I found it very intriguing that you quote the Hippocratic Oath, "First, do no harm." I also found it very heartening that you take the position that "we do believe it is unethical and unprofessional for a physician to participate even to the extent of pronouncing the prisoner dead after

execution." For such participation, I believe your editorial suggests that physicians are subject to review by the Medical Disciplinary Board under the state's Medical Practice Act. It would truly be wonderful if the medical profession would develop a

consistency in its support for life in both areas of the death penalty and abortion. The execution of an unborn human who has committed no crime surely would call for your organization to write an editorial about the unethical and unprofessional conduct of physicians who engage in such practices.

I will eagerly be awaiting such an editorial.

— Allison C. Laabs
Executive Vice President
St. John's Hospital
Springfield



Editor's note: Illinois Medicine editorials are based on ISMS policy. Illinois Medicine reserves the right to edit all letters to the editor for space and style.

I read with great interest your editorial "The ethics of execution" in the May 20 edition of *Illinois Medicine*. I was very happy to see a number of the thoughts contained in your editorial, such as, "Physician participation

GUEST EDITORIAL

Latest winners of health fight: trial lawyers

By Morton M. Kondrake

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Super-lobbyist Tommy Boggs scored a stunning victory for his client, the Association of Trial Lawyers of America, on Tuesday, but in moving to gut medical malpractice reform nationwide, he may have overreached.

Two of ATLA's most consistent congressional allies, Senate Majority Leader George Mitchell (D-Maine) and House Judiciary Committee Chairman Jack Brooks (D-Texas) on Tuesday produced nearly identical health care bills potentially canceling out state efforts, many quite extensive, to bring malpractice claims under control.

Within the sweeping national conflict over health reform, malpractice reform is a theater of combat where fighting is especially fierce and expensive, although it's more obscure than the contest over employer mandates and price controls.

It pits the trial lawyers, who litigate on behalf of victims of medical mistakes and collect huge contingency fees when they win, against hospitals, doctors and malpractice insurance companies, which often pay huge sums when they lose and also pay a lot to insure themselves against loss.

Boggs, partner in the lobby-law firm of Patton, Boggs & Blow and son of former Reps. Hale and Lindy Boggs (D-La.), is the lead lobbyist for the trial lawyers.

A widely cited Harvard study found that the average U.S. doctor spends \$15,000 per year in malpractice insurance, and premiums for anesthesiology and obstetrics can go as high as \$200,000 per year.

The rate at which doctors get sued has increased ten-fold in the past three decades, and the average award in winning lawsuits has increased from \$40,000 to nearly \$150,000 over the past 20 years, taking inflation into account. Lawyers customarily collect between 30 and 50 percent of a victim's award, plus expenses.

To avoid lawsuits, doctors often practice costly "defensive medicine," ordering tests and performing procedures that wouldn't ordinarily be necessary. A recent study by the consulting firm Lewin-VHI indicates that reforms to control defensive medicine could save \$4 billion per year.

Over the past several years, medical groups have won various limits on malpractice suits in most states, including specific dollar limits in 15 states on so-called "noneconomic damages," such as "pain and suffering."

California, for instance, limits noneconomic damages to \$250,000; Massachusetts and Maryland, \$500,000; and Michigan, \$225,000.

The medical providers and business lobby, the Health Care Liability Alliance, has been urging similar limits be passed as part of national health legislation while ATLA has been fighting against them.

Now, Mitchell and Brooks are backing a provision for federal law to pre-empt state limits, but Boggs claims the measure will not wipe out state award caps unless Congress passes its own cap. The HCLA counters that federal lawsuits are certain to be filed against state limits, claiming that Congress opposes caps.

If ATLA prevails in Congress, it will be Boggs' second major triumph this year.

On June 29, the Senate fell three votes short of the 60 votes necessary to break a filibuster led by another ATLA acolyte, Sen. Fritz Hollings (D-S.C.), against legislation limiting awards and legal fees in product liability cases.

In another demonstration of its power, ATLA intervened with then-House Ways and Means Committee Chairman Dan Rostenkowski to slice a \$350,000 cap on noneconomic damages out of the health care bill approved by the panel's health subcommittee, on the grounds that Brooks' committee had jurisdiction over the topic.

To gain influence, ATLA contributes lavishly to campaigns — \$4.4 million during the 1992 election cycle and \$235,000 so far in this cycle, according to Federal Election Commission filings. The health industry is spending just as lavishly, but it has numerous objectives in the health care reform fight, whereas ATLA's money is narrowly focused on product liability and medical malpractice.

Despite a close relationship between ATLA and President Clinton, the administration's health care bill contained some measures sought by the health industry, including 33-percent limits on lawyers' fees and a mandate that parties try mediation before filing lawsuits.

The Clinton bill contained no limits on damage awards, but the Senate Finance Committee wrote a \$250,000 limit indexed to inflation. Mitchell's bill, naturally, contains no such limit and eliminates state caps. House Majority Leader Richard Gephardt (D-Mo.) has yet to decide whether to incorporate Brooks' measure into his health care bill.

Boggs' success on Tuesday with Mitchell and Brooks stunned the health and business lobbies.

"This ought to be called the Mitchell-Brooks Trial Lawyers' Full Employment Act," said Wayne Sinclair, senior vice president of the MMI Companies, a malpractice insurance firm. "It amazes me that the trial lawyers are not only trying to block reform, but they've gotten greedy."

With any luck, overreaching will rebound against the lawyers. In the House, Rep. Vic Fazio (D-Calif.) is working on Gephardt to keep Brooks' provisions out of the House leadership bill and safeguard his state's reforms. In the Senate, numerous amendments to Mitchell's bill will be proposed.

Mitchell's willingness to compromise on employer mandates improves the chances that some health care legislation will pass this year, but it would be a shame if it contained a windfall for lawyers.

Trial lawyers
attempt to
thwart federal
tort reform
efforts

PAGE 5

ISMIE Update

Plaintiff attorney
attends Lake
County mini-
internship
program

PAGE 10

A doctor's perspective on facing a lawsuit

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By David Chapin, MD

A 35-year-old mother of two who had experienced pelvic pain for about four years consulted me for evaluation and possible treatment. She dramatically described pain that often awakened her at night and prevented her from performing her normal household activities.

Two years prior to her visit to my office, she had had a laparoscopy. The pelvis was normal by report. Prior to seeing me, this patient had consult-

ed two other gynecologists in the Boston area; both had recommended hysterectomy and bilateral salpingo-oophorectomy for a diagnosis of presumed endometriosis. Mine was her third opinion.

I reviewed the operative note from the previous laparoscopy, and my examination of the patient was totally normal. I did not believe endometriosis to be the cause of her symptoms. Having reviewed the subject of chronic pelvic pain extensively for various lectures and conferences, I felt that a hysterectomy was not likely to cure the patient's pain. I recommended against surgery and suggested that psychotherapy and/or

relaxation techniques might help her minimize the impact of her pain. (Multidisciplinary pain management units were not yet available at the time of this patient's consultation.)

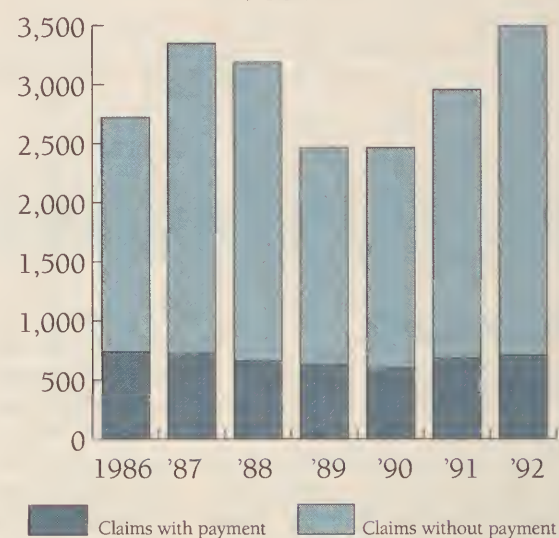
Eighteen months later, she returned with the same complaints, and my examination was again completely normal. I reiterated that surgery would be a drastic form of therapy with less than high expectation of success. I never saw her again as a patient.

The following year, the patient sued me, alleging failure to diagnose, failure to perform indicated surgery, alienation of her husband's affection and other oner-

(Continued on page 7)

Closed medical malpractice claims in Illinois*

1986-92



Source: Illinois Department of Insurance,
1994 Medical Malpractice Claims Study

*Payment reflects indemnity paid by insurance companies only.

MALPRACTICE ROUNDUP

Physician not liable for failing to advise of gastric contents

A family practitioner who failed to tell physicians performing a cesarean section on his patient that she had recently ingested iced tea and crackers was not liable for her death from aspiration of gastric contents, according to a New York court ruling. The court's decision in *Rich vs. Dionko*, described in the *Malpractice Reporter*, was based on the fact that a nurse had advised the surgeon of the woman's last oral intake and that the anesthesiologist had asked about oral intake when he took her history prior to surgery. The court also noted that the physicians should have considered the possibility of gastric contents because of the known decreased intestinal motility in pregnant women.

In addition, the court concluded that even if the family practitioner was negligent in failing to disclose the presence of gastric contents, that negligence was not the proximate cause of the patient's death. ■

Failure to diagnose led to stroke

A Missouri appellate court ruled that a physician could be found negligent for failing to diagnose carotid artery disease that resulted in a patient's stroke, even though the patient never informed her physician that her symptoms – including a tingling sensation in her limbs, vision loss and the drooping and falling of an arm – predominantly affected her left side. According to an article in the *Malpractice*

Reporter, the plaintiff in *Hiller vs. Diestelhorst* filed suit because she suffered a stroke after tests the physician ordered showed no irregular heart function. She had been treated previously at another hospital and was diagnosed with hyperventilation. No reference was made to any symptoms affecting her left side, the article said.

Although the patient claimed that she told the defendant-physician about the location of the symptoms, he testified that when he asked if any of her symptoms were more prevalent on one side, she answered no.

The trial jury found for the defense. But the patient appealed, calling inappropriate a jury instruction indicating the physician could not be found liable if the plaintiff had failed to inform him that the symptoms occurred mainly on her left side, the story said. The appellate court agreed, stating that the physician could be negligent for failing to diagnose carotid artery disease, even without knowledge about the left-sided nature of the symptoms. The appellate court reversed the trial jury's verdict and remanded for a new trial.

The plaintiff's case was helped by testimony from a medical expert who was also not told that the patient's symptoms were worse on the left side. The expert testified that the defendant did not adequately investigate whether the patient's symptoms were caused by a neurological problem, since he failed to perform a physical neurological examination or seek a neurological consult. In addition, the defendant-physician failed to order tests of the patient's carotid arteries to determine the presence of a blockage, the expert testified.

According to the article, the plaintiff made a case for negligence without proving that she notified her

physician about the predominance of symptoms on her left side. ■

Court decreases Upjohn judgment

An Illinois appellate court ruled recently that a \$35-million punitive judgment against Upjohn Co. was excessive and should be reduced to no more than \$3 million, according to a report in the June 29 *Chicago Tribune*. The ruling resulted from a lawsuit filed in 1984 by a Park Forest man whose eye had to be removed after it was injected with Depo-Medrol, a corticosteroid manufactured by Upjohn. The punitive award had previously been reduced to \$35 million from the \$124 million granted by the trial jury, the article said. The revised \$3-million judgment still ranks as the largest punitive-damage award ever assessed in Illinois, according to the article.

During the 1992 trial in Cook County Circuit Court, the plaintiff claimed that the drug was not FDA-approved for use in treating eye disorders and that Upjohn failed to inform physicians about the 23 reports of adverse reactions, including blindness, the company received about such off-label usage, the article said. Although the appeals court agreed with the circuit court opinion that Upjohn's actions supported a punitive damage award, the higher court ruled that there was "no reasonable relationship between the amount of the punitive damages and the harm caused by the [company's] conduct." The court also noted that a "punishment in the amount of 2 percent of [Upjohn's] net worth seems to us excessive in the extreme." ■

A doctor's perspective

(Continued from page 6)

ous charges. I was devastated. Her charges attacked my attempt to be conservative, my attempt to save her from what I considered an unnecessary operation and my attempt to treat her as a whole person rather than a pelvis with pain.

There is no describing the feeling of shame engendered by having to say, 'No, I am the defendant in a malpractice case.'

Through the pretrial process, I discovered that the patient had sought yet another opinion subsequent to her second visit with me. This doctor had performed a laparoscopy and announced that her pelvis was riddled with endometriosis. He later performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Thereafter, the patient alleged, she had much less pain. The pathology report, however, revealed that the uterus, tubes and ovaries were completely normal, and no endometriosis had been found.

During the two and a half years that it

took for this case to wend its way through the tedious process of interrogatories, depositions, meetings with the attorney and waits for court times, my daily life was disrupted. The spectre of this looming litigation gave rise to feelings of anger, fear, malaise and occasional nausea.

I attended the entire five-day trial. On the first day, I ran into an old friend who was in the courthouse for jury duty. He asked if I was there for jury duty, too. There is no describing the feeling of shame engendered by having to say, "No, I am the defendant in a malpractice case."

When they were on the stand, the patient and her husband were severely accusatory, but smiled at me when seated in the spectators' benches. Their expert witness, who was a graduate of the residency program to which I had just moved, testified that I should have performed at least another ultrasound if not another laparoscopy. When asked whether the negative findings in the pathologic specimen did not cast doubt upon the laparoscopic findings of the operating surgeon, he hemmed and hawed and said he didn't think so.

Between court sessions, this physician approached me and actually apologized, saying, "I'm really not doing this because I think you were negligent." I had been advised not to speak to him, but I thought, "So then why are you doing it, other than for a fast buck?" Fortunately, my attorney was very clever in making this expert seem less expert.

When my attorney questioned the plaintiff, he exposed three other lawsuits

she had pending against another physician, a retailer and an accountant. He convinced the jury that she was attempting to make a living by lawsuits.

The jury found in my favor, and the case was closed.

I did not win in this situation, I only did not lose. Months of anguish, self-doubt, distraction and humiliation, as well as a week of lost work, do not constitute winning. A malpractice suit is in many ways a game. The plaintiff is in pursuit of the doctor's money and attacks with offensive language. The doctor is an unwitting player and is likely to perceive the attack as personal rather than greedy. Perhaps understanding the

nature of the game can help make the experience a little less devastating. ■

Dr. Chapin is director of gynecology at Beth Israel Hospital in Boston.

Editor's note: ISMIE is sponsoring a series of seminars around the state designed to help physicians cope with the stresses associated with malpractice litigation. "Taking Control: Managing Your Malpractice Lawsuit" is scheduled for Sept. 28 in Rosemont, Oct. 19 in Collinsville and Nov. 2 in Oak Brook. For more information, call the ISMIE risk management department at (312) 782-2749 or (800) 782-4767, ext. 1327.

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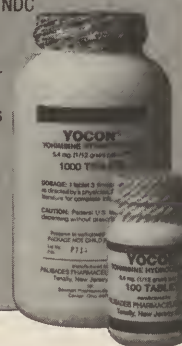
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological Basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Managed care

(Continued from page 1)

and patient satisfaction should be physicians' first step in creating a marketing plan.

"Many physicians have never assessed their practices," she noted. "But it's important to do that because managed care organizations are basing [contracting] decisions on quality standards, treatment protocols and patient satisfaction. It's all part of classic marketing. You have to know if your product meets your customers' needs."

Focus groups and patient surveys can yield valuable information for practice

assessments, the consultants said. According to Rynne, focus groups should target market segments that have been important to physicians in the past or represent potential pools of new patients. "One good idea is to get patients who recently have started coming to you and find out how they heard about your practice and how satisfied they are."

Information garnered through focus groups of referring physicians can benefit specialists, since they rely heavily on referrals from primary care providers for patients, Rynne said. A professional shopper analysis, in which someone hired from an outside organization

makes an unannounced visit to review a practice, is also useful, he said. Such an analysis can reveal practice characteristics like the average waiting time and the interaction between office personnel and patients. "The 'shoppers' pay special attention to those moments of truth when patients either turn on or off," he explained. "It is qualitative vs. quantitative market research and can help physicians identify and understand their habits and change them if necessary."

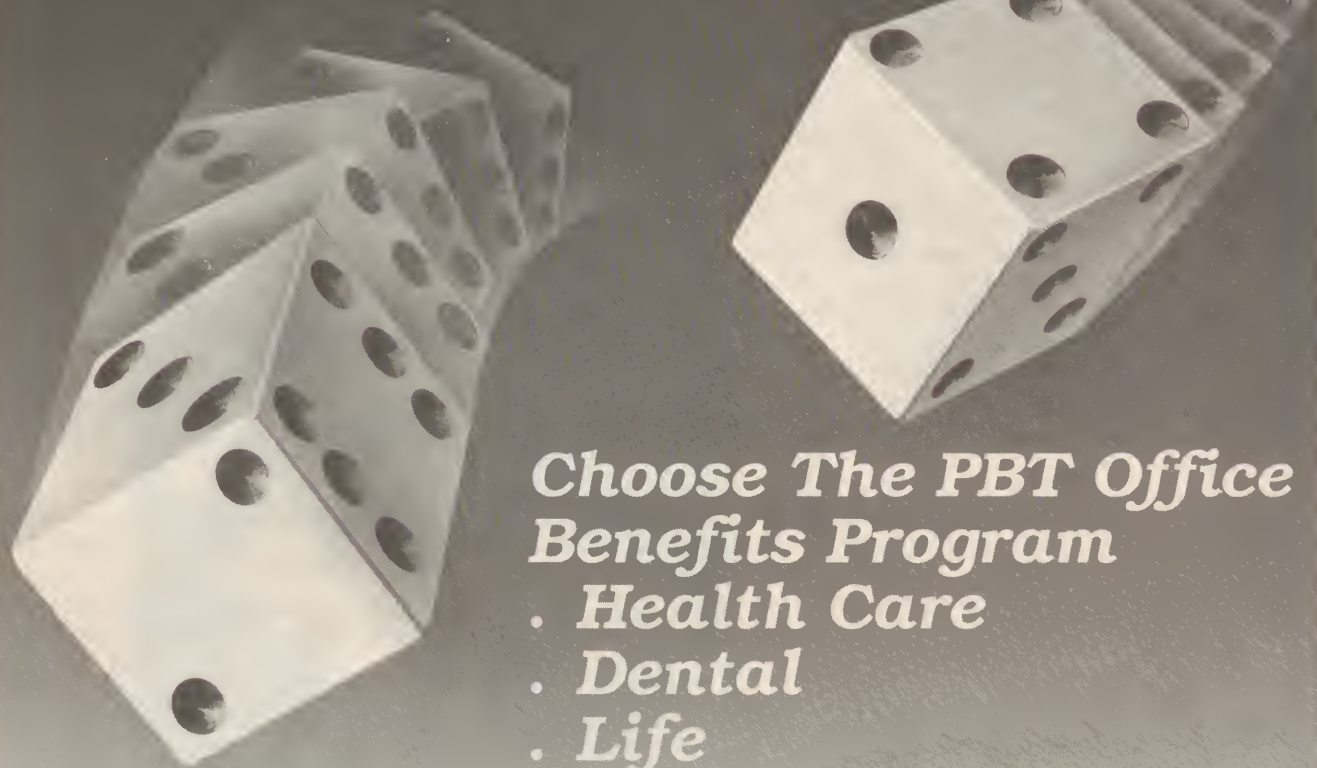
Surveys measuring patients' satisfaction are also useful, according to Zupko and Harris. "Physicians have to realize managed care organizations are surveying patients, because when patients are satis-

fied, they comply with physicians' orders. And that means the physicians get better [clinical] results," Zupko said.

Physicians should also determine the potential buyers of their services, Harris said. "Is there an opportunity to market to employer groups? Managed care plans? Third-party payers? Physicians have to assess their needs as well."

ONCE THE PRACTICE assessment is complete, physicians should communicate their strengths to all potential "customers," the consultants said. Although the specifics of doctors' marketing plans will vary depending on the size and scope of their practice, the target audiences and

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the market in which they operate, there are some standard approaches all physicians can use.

A brochure "telling the kind of practice you're in, what your hours are and a little bit about each physician in the practice" is an essential marketing tool, Harris said. Rynne agreed that practice brochures can be helpful, but he stressed that these publications must have a "headline or hook that means something to people. Paper and gloss don't sell your practice. Slickness has nothing to do with success."

In addition, direct mail pieces should be targeted at women, because they make most of the health care decisions

for families, and underserved patients, Rynne recommended. "Find out who newcomers to the community are and reach them before they ask their neighbors for a referral. Find out how your patients found out about you and tap those resources."

Rynne also listed community outreach efforts, newsletters and publicity as "some of the most efficient and cost-effective ways to get word out about your practice." Ob/Gyns, for example, can give presentations about prenatal care to community groups that attract women of child-bearing age, he said.

Newsletters can help physicians "stay in front of their patient base" by provid-

ing updates on the practice, Rynne noted. "If a patient sees you only once a year, you're not going to be at the forefront of their consciousness," he explained. "Because patient-to-patient referral is the most frequent source of patients for primary care physicians, why not remind them you're there by telling them what's going on in the practice? And make sure they know which insurance plans your practice is associated with. Sometimes patients don't realize their choice of plans led them away from you. Don't just let them go. They can change plans every 12 months, so let them know you really do care about them and that the next time they choose,

they can choose you."

Publicity generated by "a good PR-oriented writer" can also publicize a practice to the local community and beyond, Rynne said. His company has placed feature stories about a doctor who served in the military during the Gulf War and a physician who did a lot of volunteer work in his area and was the first African-American open-heart surgeon in the community. "Publicity can be the most powerful marketing mechanism, and feature stories are the most successful because they appear less self-serving than direct mail or advertising," he noted. "But you have to know what's newsworthy from a human interest or clinical standpoint." ■

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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MINI-INTERNSHIP PROGRAM

Physicians give the public a closer look at medicine

Businesspeople, attorneys, health administrators and journalists find out firsthand what it's like to practice medicine today.

BY JANICE ROSENBERG

On a Monday morning at Victory Memorial Hospital in Waukegan, calm and order reigned as orthopedic surgeon Bruce Hamming, MD, prepared to perform arthroscopic knee surgery. Around him, the surgical team worked efficiently, moving a video screen into place, unwrapping sterilized equipment and anesthetizing the patient. Everything was business as usual except for the gowned and masked observers who stood on the sidelines straining to catch every detail.

The individuals watching were three of nine "interns" participating in this year's Lake County Medical Society Mini-Internship program. On May 23 and 24, the interns spent their time in close contact with physicians on staff at Victory Memorial Hospital, Condell Medical Center in Libertyville, Lake Forest Hospital and Highland Park Hospital. In operating suites, hospital rooms, emergency rooms and physicians' offices they discovered firsthand what it means to be a doctor.

"I was very impressed with the skill of the surgeons I saw," said Scott B. Gibson, an attorney who practices in Waukegan. "I was impressed with the teamwork concept. All the players knew their roles and did them without much direction. I was treated nicely, warmly. People were very open and willing to answer questions."

The Lake County program was instituted in 1989. "The aim of the internship program is to open a channel of communication between physicians and local people who influence medical care in the area, whether they're disseminating information about it or are opinion leaders," said James Monahan, MD, chairman of the society's Community Relations Committee. "People get a realistic idea of what modern medical practice is like."

TWENTY-SEVEN PHYSICIANS volunteered for the program this year. Orthopedic surgeon Thomas Baier, MD, has participated several times. "To do surgery, you have

to learn to think objectively, in an almost callous way, but this internship experience has taught me you can get too much that way. Talking to the interns brings me back to reality. What I take as routine is a complete shock to someone who never sees it."

Over the years, program participants have included legislators, attorneys, insurance company executives, teachers and reporters. Attorney Gibson's presence caused a minor stir: His law practice focuses exclusively on personal injury cases, and Gibson often represents patients in malpractice litigation. He said he signed up for the program because he thought seeing the stresses of surgery, the unexpected events and doctors' reactions would make him a better lawyer.

In describing Gibson, general surgeon Richard Furman, MD, said, "He was a reasonable guy. In a social situation, we'd be able to talk and not be at each other's throats." Dr. Furman noted that everyone in the operating room was strongly conscious of Gibson's presence. He compared the experience to "driving down the road at the speed limit, but with a police officer behind you. I enjoyed having him. It was fun getting his view of [some difficult] situations."

Intern Emily Hartnell, a planning analyst at Baxter/Bio-Tech North America in Deerfield, is new to the health care field. She participated in the internship to meet doctors and to see what a typical day is like for them. Hartnell joined Dr. Monahan on rounds at two hospitals and was surprised at and impressed with what she saw.

"He has to make decisions like whether to [recommend] prostate surgery for a man in his 80s who's in poor health," she said. "I was aware of the issues surrounding keeping patients alive, but this interim decision-making is different, and in this country, society hasn't given doctors guidance."

Hartnell went into the internship under the impression that when doctors are unsure of a diagnosis, they order "lots of tests" because they fear lawsuits if they

MINI-INTERNSHIP PROGRAM

don't check everything. "I thought that needed to stop due to the costs, but from the internship, I got a feeling that doctors may have more reason to worry than I'd thought."

Intern William Mays is director of medical services for the Lake County Health Department. After working in public health for 25 years and serving as an army medic during the 1960s, Mays said he thought he knew medicine. However, the program not only gave him a closer look at the latest technical innovations, but also altered a long-held stereotype, he said.

"I had thought that a medical specialist didn't see a whole person, that they saw organs and bones. But that's absolutely not true," Mays said. "The ones I watched dealt with their patients as whole persons. Without exception, they and their support staffs were professional, caring and congenial."

The executive editor of Waukegan's *News Sun*, D.G. Schumacher, viewed the internship as one of the best community-relations programs in which he has participated. "Anytime you can bring people into your place of business, you're going to widen understanding, and understanding is the key to better relationships."

As a drug representative for Schering Corp., Jon Hotter spends a lot of time in physicians' offices. As an intern, he appreciated the opportunity to watch surgeons at work. "Now, if a physician says he doesn't have time for me, I'll have a better understanding of what a tough day in surgery is like. I'll be more tolerant of physicians in their office settings."

Although the Lake County Medical Society sponsored its own mini-internship program, ISMS assists other Illinois county medical societies and their alliances in organizing programs. Earlier this year, mini-internship programs were conducted by the Peoria Medical Society and its alliance, as well as the county medical societies and their alliances in Kankakee, McLean, Winnebago, Sangamon, St. Clair, Effingham, Macon, Will-Grundy, Madison and Livingston counties. The Chicago Medical Society program is scheduled for the fall.

Rockford attorney Richard Van Evera attended the Winnebago County mini-internship program. He said that any American who believes physicians are making too much money should attend an internship program. "Seeing the commitment, long hours and dedication physicians put into caring for people would add a dimension to the discussion of health care. Cost is a valid question we can't lose sight of, but we should jealously guard the aspects of our system that provide us with the best health care in the world."

Peoria intern Dave Ransburg also appreciated the opportunity to view the diversity of health care services offered by his city medical complex. But as CEO of L.R. Nelson Corp., he said he is concerned about the increasing cost of health insurance for his employees. He called his experience at the local internship program "useful" but said that seeing quality health care delivered in person did not change his opinion that costs are out of control. Nor did it make him feel better about the money he spends to cover his employees.

"I would hope the medical community would find a way to contain the costs without having Washington do it," he said. "The medical community won't like that solution in terms of caps, and we won't like it in terms of rationing that may occur."

PHYSICIANS WERE PLEASED to allow participants the chance to observe them. Dr. Hamming said internships can show the public that physicians are "just people" doing a job to the best of their ability. "The more they see us that way, the better we can all work together for the general good in health care."



Chip Zellet

Radiologist Sankara Peruri, MD, and his intern William Mays (center) watch as technician Scott Nelson performs a CT scan.



Steven Marquart, MD (left), an anesthesiologist at Condell Medical Center in Libertyville, describes his responsibilities during surgery to intern Emily Hartnell.

Most physicians saw the value in helping more people experience the practice of medicine from the doctor's viewpoint. "It would be good for our politicians who are trying to help straighten out health care reform to see this," said Dr. Baier. "So many talk about reform who don't know what the doctor does and the pressure we're under to make decisions."

Asked to suggest an ideal intern, Dr. Furman said he'd like to invite Hillary Rodham Clinton, but she would probably not attend. He recommended, as a more realistic candidate, Ty Wansley, a talk-show host on Chicago's WLS radio station. Dr. Furman said he figured Wansley, like most interns, would want to talk about his experience. "Mini-interns talk to their friends, which gives a cascade effect and makes more impact."

Dr. Furman said he participates in the Lake County program because he loves to teach. But his main purpose for signing up each year is to give more people insight into the physician's world. "There are so many difficult decisions the country has to make regarding health care. One thing we can do to get people to see our side of it is to have them do an internship." ■

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Antitrust amendment

(Continued from page 1)

severe disadvantage because of the ability of large corporations to buy up large groups of patients, leaving physicians with no collective voice regarding [issues] like quality and conditions of employment," Dr. Todd said.

As *Illinois Medicine* went to press, Gephardt had failed to incorporate the Canady antitrust provision into the leadership's health reform legislation, according to sources from the Washington Presence program and the AMA.

"We view the amendment as extremely important because antitrust relief is so vital for physicians," said ISMS President Alan M. Roman, MD.

Passage of the amendment was a sig-

nificant first step for doctors and patients, said William Kobler, MD, chairman of the ISMS Hospital Medical Staff Section. "In an era [in which] large organizations like hospitals and insurance companies are trying to involve themselves in control of the health care delivery system, the ability of physicians to collectively negotiate is important. Antitrust reform would give physicians the ability to negotiate on behalf of patients without having to form corporations or formal group practices. It's in the best interest of patients, because physicians – not direct payers – still play the role of patient advocate."

Canady's revised amendment would exempt certain activities from antitrust laws if they fell within one of seven safe harbors that prohibited price fixing,

group boycotts or other coercive or anti-competitive conduct, the AMA said. The antitrust provisions in the amendment are similar to those in the Health Care Quality Improvements Act of 1993 sponsored by Sens. Orrin Hatch (R-Utah), Strom Thurmond (R-S.C.) and Rep. Bill Archer (R-Texas), according to the AMA. The adopted amendment differed from Canady's first proposal in that it contains an AMA-drafted clarification stating that the provision would not "prevent another professional group from exercising its legal rights," Dr. Todd explained.

The type of antitrust relief included in the Canady amendment is important because it facilitates network formation by all providers, including doctors, Dr. Todd said. Current antitrust laws

impede competition because they "discourage network formation by providers and favor the organization of networks by insurance companies," he noted. "The AMA believes that no one provider or institution should be favored by the law in the development of networks. Network formation should come from a diverse set of sources, including physicians, hospitals and insurance companies, and they should all compete for success in the market."

"We don't know at this point if this provision will make it onto the House floor for deliberation. We need to continue our vigilance and efforts to ensure that antitrust relief for physicians gets a fair hearing," Dr. Roman said. ■

Hospital groups

(Continued from page 1)

ments Act of 1993 contains an antitrust exemption for certain groups of providers, such as physicians, [that] would immunize a broad range of activity, including enabling nonintegrated providers to organize solely for the purpose of negotiating fees."

Pollack added that such exemptions "discourage true integration, could result in higher health care costs and fail to promote change from the status quo in the way we deliver care."

An Illinois Hospital Association spokesperson said she could not address the issue of whether physicians should be included in the same antitrust reforms

as hospitals, because IHA has not taken a position on antitrust relief for doctors and would have to study the issue.

"ISMS is concerned that AHA is so blatantly opposing the inclusion of necessary antitrust relief for physicians in federal reform legislation," said ISMS President Alan M. Roman, MD. "Doctors need these antitrust reforms to collectively advocate for their patients in the changing health care marketplace. But we're afraid that Rep. Richard Gephardt, the House majority leader, is unwilling to support the amendment of physician antitrust relief onto his reform bill. At the same time, he seems receptive to so-called medical liability reforms crafted by the trial lawyers' lobby that reverse physician efforts to stabilize the medical malpractice climate.

Caps on noneconomic damages and antitrust relief for physicians remain critical to the success of reform."

The AMA, too, questions the AHA's opposition to statutory antitrust relief that includes doctors, according to James Todd, MD, AMA executive vice president. "Where the AMA and the AHA part company is whether the reforms should facilitate the development of networks by all kinds of providers or whether only one type of provider should have the lead role," Dr. Todd explained. "It is becoming increasingly apparent that hospitals want to control the networks and that they do not want competition from physicians."

"The AHA supports reforms that facilitate integration and collaboration

between hospitals, physicians and other providers and that lead toward our vision of a restructured delivery system based on multiprovider networks," said AHA attorney Gaelynn DeMartino. The AHA's support of antitrust relief for all providers is contingent on the complete integration of providers, she added.

Although the AHA claims antitrust reform for physicians would fail to promote integration among different types of providers, many antitrust reforms sought by the AHA would facilitate transactions among hospitals, Dr. Todd said. "Hospitals want to be able to form community networks and control physicians. If physicians are given the ability to collectively come together, the hospitals' power will be diminished." ■

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GPCI reductions

(Continued from page 1)

scheduled to meet with HCFA officials to discuss potential ways to soften the negative impact of the proposed changes, Dr. Welch said. The meeting was arranged through ISMS' Washington Presence program. "In this session, we hope to explore the GPCI findings more fully, discuss the integrity of HCFA's methodology and data and appeal for redress," Dr. Welch explained. Besides the meeting, ISMS is submitting written comments to HCFA detailing Illinois physician concerns about the proposed changes.

"ISMS is exploring potential legislative advocacy to mitigate the future impact of the new GPCIs for Illinois physicians," Dr. Welch continued.

In addition, ISMS leadership contacted AMA Board Chairman P. John Seward, MD, a Rockford physician, and requested the AMA's assistance. "As a result, AMA and ISMS analysts are meeting to explore underlying data problems, as well as potential advice and assistance to aid in our corrective efforts," Dr. Welch said.

HCFA'S REASONING for targeting Illinois for lower GPCIs is not necessarily accurate, an ISMS analyst said. Based in part on the use of proxy data, HCFA maintained

that overhead costs and the salaries of highly skilled professionals in Illinois have not increased as much as in other states, he explained. However, ISMS and AMA analysts believe that an incomplete picture of physician expenses is created by the data HCFA chose as a basis for the GPCI changes. For example, HCFA used current data from the U.S. Department of Housing and Urban Development to help calculate the practice GPCIs. But the HUD data should not have been used because they are based on residential rental rates, which do not adequately reflect doctors' rent costs in commercial buildings, according to ISMS and AMA analysts.

The news for Illinois physicians facing lower-than-expected increases from the revised GPCIs is not all bad. Their effect will be softened because they will be phased in over two years. And since GPCIs are not the sole factor in determining physician reimbursement, some of the effects of the GPCI changes may be lessened by other changes in the fee schedule, the ISMS analyst said. For example, each Jan. 1, fee schedule conversion factors are increased for all procedures. In addition, as the RBRVS phase-in continues, fees for services such as evaluation and management procedures are expected to rise. These increases will help balance the GPCI decreases, he said. ■

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • SEPTEMBER 9 1994



Theater as
therapy

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ISMS BEHIND THE SCENES

SOCIETY CARRIES GPCI CONCERNS TO WASHINGTON

ISMS representatives traveled to the nation's capital Aug. 15 to express concerns about the U.S. Health Care Financing Administration's proposed changes to the geographic practice cost indices of the Medicare RBRVS formula. GPCIs - which reflect expenses related to physician work, practice overhead and malpractice liability expenses - measure the costs of operating a practice in each Medicare fee area compared with the national average.

The meeting between ISMS and high-level HCFA officials was arranged through the Society's Washington Presence program. Representing ISMS physician leadership were John Schneider, MD, ISMS Third District trustee and chairman of the Third Party Pay-

ment Processes Committee, and Arthur Traugott, MD, ISMS trustee-at-large. Former Illinois Gov. James Thompson of Winston & Strawn also attended the meeting to advocate on behalf of Illinois physicians.

"We indicated our concerns," Dr. Schneider said. "They brought in HCFA chief Bruce Vladeck and those responsible for actually making the GPCI calculations. HCFA didn't have a reason why Illinois did poorly compared to other states. All they could do was explain the process used to calculate the GPCIs."

Specifically, ISMS leadership questioned the methodology used in calculating the new GPCIs and expressed apprehension that the

(Continued on page 6)

Self-referral laws impact physicians

REGULATIONS: Doctors must look at federal and state law for compliance requirements.

By Kathleen Furore

[WASHINGTON] New provisions in the Omnibus Budget Reconciliation Act of 1993 that go into effect Jan. 1 will expand the ban on patient referrals to facilities and equipment companies in which physicians or their family members have a vested financial interest. The OBRA '93 self-referral provisions significantly broaden the reach of legislation sponsored by U.S. Rep. Pete Stark (D-Calif.), which became effective in January 1991. The Stark legislation prohibits physicians from referring Medicare patients for laboratory tests to facilities in which doctors have a financial stake, according to a summary published in the Southern Illinois University Law Journal and written by attorney Latham Williams, a partner in the Chicago offices of Sidley & Austin. The new federal law

still applies to referrals only for Medicare and Medicaid patients, Williams said.

The expanded federal legislation prohibits referrals for clinical laboratory work, physical and occupational therapy, radiology and diagnostics, radiation therapy, home health care, and inpatient and outpatient hospital services if those referrals are made by physicians who have financial relationships with the providers of the services, Williams explained. The law also bans referrals of patients to companies if doctors have a financial interest in them and if the companies are involved in the production and sale of durable medical equipment; outpatient prescription drugs; prosthetics, orthotics and prosthetic devices; and parenteral and enteral nutrients, equipment and supplies, he noted.

(Continued on page 11)

Cost cutting prompts home-based program

PATIENT EDUCATION: A Springfield hospital helps soften the effect of shortened maternity stays. By Anna Chapman

[SPRINGFIELD] Insurance companies' attempts to contain costs by requiring shorter hospital stays for new mothers are making home care a necessity in some cases, said Sandra Bilinsky, MD, a private practice pediatrician in Springfield. The Beautiful Beginnings Come Home program, implemented in February by St. John's Hospital in Springfield, is meeting those needs.

Through the program, the hospital has sent postpartum nurses to visit more than 500 new mothers and their infants three days after the patients' discharge from St. John's, according to the program coordinators.

ALL PREGNANT St. John's patients may participate in the program, but they must be referred by a physician, Dr. Bilinsky said. The hospital does not charge for the service, which includes a home visit from a prenatal nurse 30 weeks into the pregnancy and again three days after the mother and infant return home, program officials said.

According to Dr. Bilinsky, the

program was created because more insurance companies dramatically reduced the number of hospital days covered for new mothers. Physicians were reluctant to send women home within 24 hours, especially if it

MANAGED CARE

was their first delivery, she noted. "It was a burden for women to come in to the office for neonatal screens."

"When we came to see that short stay was going to be the norm rather than the exception, we put together the program," said Eileen Streb, RN, a program coordinator and supervisor of the hospital's birthing center. Currently, seven postpartum nurses work part-time on the home program and part-time in the obstetrics department. "We have two to three nurses a day doing nothing but home visits," she said.

A major emphasis of the program is teaching the mother about parenting, breast feeding

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INSIDE

Early detection of
mental disorders
urged



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DEPARTMENTS

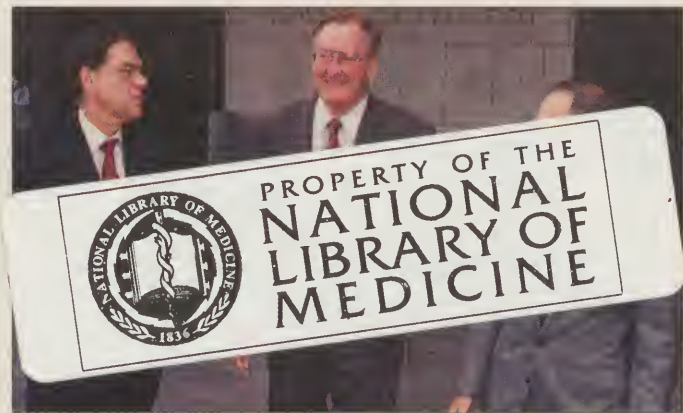
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WHILE IN WASHINGTON to meet with HCFA officials, former Gov. James Thompson (center) and ISMS trustees John Schneider, MD (left), and Arthur Traugott, MD, gather in front of the Department of Health and Human Services.

David Hathcox

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Grant Hospital establishes section of holistic and preventive medicine

NEW SERVICES: Traditional and alternative medicine join forces.
By Kathleen Furore

[CHICAGO] To help bridge the gap between conventional and alternative medicine, Grant Hospital has teamed up with the Chicago Holistic Center to establish a hospital-based section of holistic and preventive medicine, according to hospital officials at a July press conference.

The new division will promote principles of holistic medicine that complement traditional Western medical practices and conventional drugs and surgery, said David Edelberg, MD, the section's chief and founder of the Chicago Holistic Center. "Combining the best of both traditional and alternative medicine allows clinicians to focus on the unique needs of each patient — mind, body and spirit. The human body has a tremendous capacity to heal itself with the proper treatment and guidance."

Grant's new section will educate health care professionals and the public about holistic medicine, conduct outcome studies and offer patients such alternative services as biofeedback, acupuncture, massage and hypnosis, a hospital spokesperson said.

"This new section complements many services at Grant that have taken a holistic approach, such as rehabilitation and behavioral medicine, and the Wellness Center, which has been sponsoring health promotion programs for more than 10 years," said Arnold Kimmel, chief executive officer of Grant Hospital. "[It] addresses the market demand for more cost-effective treatments and the desires of informed consumers who want to take charge of their own health."

Because most physicians are not trained in the principles of holistic medicine, this month, the hospital will begin offering programs on such topics as incorporation of holistic techniques into an existing practice and an introduction to Chinese medicine for those interested in learning about alternative therapies. Holistic Center staffers will help conduct the classes, and participating physicians will earn CME credits, the spokesperson said. She also noted there will be a series of educational programs for all hospital staff members as well as community residents.

Patients seeking treatment will be able to visit either the hospital or the nearby Chicago Holistic Center, depending on the type of service sought, the spokesperson said. All services are performed either by physicians or by health care practitioners who are directly supervised by physicians, Dr. Edelberg said. According to ISMS policy, acupuncture is a surgical procedure that should be performed only by physicians licensed to practice medicine in all its branches and by dentists.

LOCATED IN AN UPSCALE Chicago neighborhood, Grant Hospital serves many individuals whom research has shown to be most receptive to alternative medical treatment. The use of holistic medicine was significantly more common among

college-educated people between the ages of 25 and 49 and with annual incomes exceeding \$35,000, according to a study published in the Jan. 28, 1993, issue of the New England Journal of Medicine. However, the study also reported that an estimated one in three persons in the U.S. adult population used unconventional therapy in 1990 and that this use was distributed widely across all demographic groups. Also indicative of the increasing interest in alternative treatments is the fact that the National Institutes of Health and Columbia University recently established centers to explore alternative medicine, said the Grant Hospital spokesperson. And according to an Aug. 1 article in USA Today, the federal government will spend some \$13 million this year alone for studies involving alternative medical treatments.

"As providers of health care, hospitals should take a leadership role in promoting optimum health and wellness for outpatients," Kimmel said. "Especially in this era of health care reform, the time is right for the holistic movement to join hands with traditional providers. We must improve the delivery of health care, enhance patients' well-being and emphasize prevention in a cost-effective manner. We are very excited about the new opportunities the section will bring to our hospital and the patients we serve." ■



THORACIC SURGEON RAYMOND DIETER JR., MD (center), is honored by administrator Eric Myers (right) and nurse manager Mary Frederick for performing the first operation at the new Center for Surgery in Naperville.

Physicians must report Lyme disease, E. coli infections

PUBLIC HEALTH: Specific lab tests are available to help doctors accurately identify reportable illnesses. By Anna Chapman

[SPRINGFIELD] As the peak season for Lyme disease continues, physicians should keep in mind possible diagnostic problems, said Carl Langkop, chief of the Illinois Department of Public Health's communicable disease control section. The symptoms of Lyme disease often mimic other ailments, making it difficult to diagnose, and clinical presentation and progression can differ widely, he said.

Bone and joint symptoms can mirror arthritis, he said. And certain cardiac manifestations from other causes are also mistaken for Lyme disease, he noted.

Physicians are required by law to report Lyme disease cases to their local health departments, according to IDPH.

Physicians should also be aware that lab results can be affected by the presence of other diseases like infectious mononucleosis, rheumatoid arthritis, other spirochetal diseases, such as periodontal disease, and systemic lupus erythematosus.

The ELISA and Western blot tests are the most reliable ways to substantiate Lyme disease diagnoses, Langkop said.

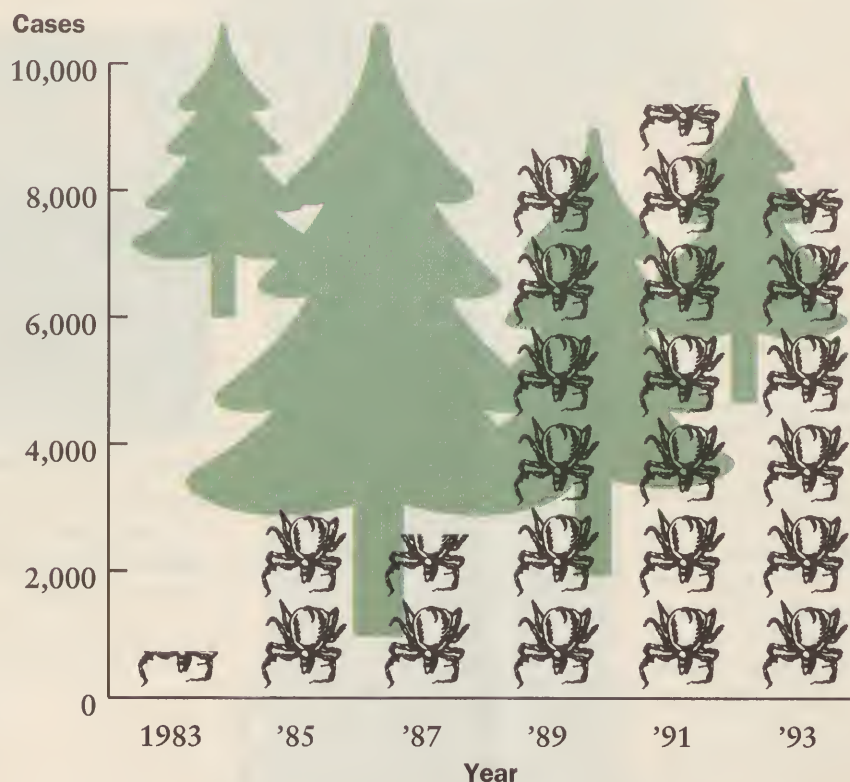
PHYSICIANS ARE ALSO responsible for reporting cases of E. coli O157:H7 to their local health departments. This new requirement went into effect on July 15, Langkop said.

Fifty-six cases of E. coli O157:H7 were reported in Illinois through August, compared with 45 cases last year, when reporting was not mandatory, according to IDPH.

Langkop noted that it is impossible to detect E. coli O157:H7 through methods used to isolate and identify other bacterial enteric pathogens. "In order to isolate this organism, sorbitol-MacConkey medium should be used. All patients with bloody diarrhea should be cultured for E. coli O157:H7. Sorbitol-negative E. coli isolates should be serotyped to determine if the organism is serotype O157:H7," he said. An IDPH laboratory in Chicago performs the serotyping necessary to detect the E. coli O157:H7 organism, Langkop noted. The lab is located at 2121 W. Taylor St., Chicago, IL 60612. ■

PHYSICIAN FACTS

Reported cases of Lyme disease in the United States 1983-93



Source: Morbidity and Mortality Weekly Report, 1994

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Early detection of mental disorders urged

PREVENTION: Physicians play a major role in identifying kids at risk. By Janice Rosenberg

[CHICAGO] More money should be spent on identifying, treating and preventing mental illnesses in children and adolescents, according to participants in a June panel discussion sponsored by the Scientists' Institute for Public Information. The group is a national not-for-profit organization dedicated to increasing public understanding of science and technology by providing journalists with access to top scientific sources.

"We talk about loving our children. We idealize them as the future of the nation, but our nation is at risk because we haven't invested in them," said Beatrice Hamburg, MD, a child psychiatrist. "That's extremely obvious in the prevention area, where you have to do continuous nurturing of your youth, and we don't do that."

Prevention of childhood mental health problems begins with good prenatal care, Dr. Hamburg said. Women need to see physicians early in their pregnancies, and doctors should ask their pregnant patients about smoking, drinking, general health habits and stress.

As children grow, physicians should play an active role in identifying those at risk for mental illness. Dr. Hamburg said pediatricians should monitor children to see that they are meeting normal developmental milestones, and if they are not, physicians should ask about their living situations. Doctors should also monitor parents' behavior during children's examinations, she said.

"Children usually present with behavioral disturbances rather than telling you how they feel," said Daniel Yohanna, MD, director of outpatient psychiatry at Northwestern Memorial Hospital. "Problems in school, refusal to go to school, isolation, changes in behavior, acting out and aggressive episodes are all early indications that children have psychiatric problems like depression or other disorders that affect the way they think or behave."

PHYSICIANS MUST have a heightened awareness of the signs of depression in teen-agers, noted Dr. Yohanna. Doctors should not be afraid to ask their young-adult patients, "Have you been blue? Have you ever had the feeling that life isn't worthwhile?"

"I think there's a great deal we can do [as physicians], and it goes back to doctors getting continuing education and becoming aware that they need to have some time to talk to the patient," Dr. Hamburg explained.

"The primary difficulty for us [in adult psychiatry] is that we wind up with the aftermath of the problems that weren't picked up earlier," said Dr. Yohanna. "Once you have one mental health diagnosis, you often gather more as you go through life. So the sooner that children are identified and treated, the less likely they are to come to our attention as adults."

Doctors should be familiar with area mental health specialists to whom they can refer their young patients, Dr. Hamburg said. In addition, physicians should work with parents to mobilize school and community resources, she said.

Neighborhood resources like the Mt. Sinai-Mile Square Community Mental

Health Center in Chicago help identify children at risk and offer prevention programs for them and their families. Beverly Hamilton Robinson, the center's director, said basic education about the availability of mental health services ties directly into prevention.

"Too many people don't come because they think they aren't sick enough," Robinson said. "Others avoid mental

health services because of the stigma."

People who are not treated at the earliest stages are at high risk for someday being institutionalized, the panelists said.

Implementation of a reform plan submitted a year-and-a-half ago by Gov. Jim Edgar's Mental Health Service System Advisory Council will increase the emphasis on prevention in Illinois' mental health system, said Ronald Davidson,

PhD, director of the Mental Health Policy program at the University of Illinois at Chicago. "Children's services are also being dramatically improved."

Addressing the issue of community-based preventive programs, Arthur Traugott, MD, an Urbana psychiatrist and ISMS trustee, urged caution. "Funding prevention when we can identify a cause-and-effect relationship makes good sense. But funding prevention based on unproven hypotheses is a misuse of public resources. That's why a balanced, integrated approach developed from solid data is both prudent and advisable." ■



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REPORT *for Illinois Physicians*

MEDICARE PART B CORRECT USE OF MODIFIERS 24 AND 25

Occasionally, an evaluation and management (E/M) service may be provided during a global period which is unrelated to, or goes beyond, the normal care associated with the global procedure. For this reason, modifiers 24 and 25 were established to aid in reimbursement.

Providers should use the appropriate modifier when billing unrelated E/M services during the global period. Use of the appropriate modifier will speed claim processing and assure correct reimbursement.

MODIFIER 24

Unrelated E/M service by the performing physician or any member of the performing physician's group during a postoperative period. This modifier is used to bill for visits which are furnished during the postoperative period of a procedure, but are unrelated to the procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service.

Service submitted with the 24 modifier must be documented to establish that the visit was unrelated to the procedure. An ICD-9-CM code which clearly indicates that the reason for the visit was unrelated to the procedure is acceptable documentation.

MODIFIER 25

Significant, separately identifiable E/M service by the same physician on the day of a procedure. This modifier is used to bill for E/M services on the same day as a procedure for which separate payment may be made. A physician may need to indicate that, on the day a procedure was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the care usually associated with the procedure that was performed. This circumstance can be reported by adding modifier 25 to the appropriate level of E/M service. Using modifier 25 is appropriate only for services furnished on the same day as a procedure.

As of January 1995, applying modifier 25 to an E/M service furnished during the postoperative period will result in denial of the claim.

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EDITORIAL

Getting tougher on tobacco

At last someone has developed a good use for tobacco. Researchers at Virginia Polytechnic Institute are using tobacco plants for genetic manipulation experiments. In fact, tobacco was called the "laboratory mouse" of agricultural biotechnology by one researcher at the institute.

All other uses of tobacco are, of course, a different story. About 3 million teens smoke nearly 1 billion packs of cigarettes per year, with 70 percent of teen-age smokers developing a regular habit by the age of 18, according to the U.S. Centers for Disease Control and Prevention. And these teen smokers are very susceptible to advertising. Heavily advertised brands netted 86 percent of the teen-age market but only 35 percent of overall sales, said the CDC.

Last year, Marlboro, Camel and Newport ranked first, second and third in the amount of money spent on advertising, according to a story reported by the Associated Press. What are the most popular brands with teen-age smokers? Marlboro, Camel and Newport, respectively, said the CDC.

The Federal Trade Commission recently investigated the influence of the Joe Camel ad campaign on children and teens and, unfortunately, said it could not find evidence that the campaign fostered smoking among kids.

A hefty federal excise tax hike would be a significant deterrent to young smokers, said a study conducted by an economist at the University of Illinois at Chicago and included in a 1994 report

by the U.S. Surgeon General. Specifically, the study said that an increase of \$1.01 per pack could reduce young smokers' cigarette consumption rate by more than 50 percent.

Medicine is intensifying the fight against tobacco. Last month, the AMA and the Robert Wood Johnson Foundation announced the launch of a \$10-million anti-smoking campaign in 19 states, including Illinois. In fact, Illinois is one of the states that reportedly will receive \$1 million, the largest grant awarded.

Representatives of the AMA and the foundation said they plan to use California's successful program as a model for the 19 states. In the late '80s, California voters passed a 25-cent increase in the state tax on a pack of cigarettes, and since then, tobacco use has decreased by 30 percent. Massachusetts and Michigan have also increased taxes on cigarettes and developed extensive anti-tobacco education programs.

In other recent state initiatives, Mississippi became the first state to sue the tobacco industry to recover the cost of treating tobacco-related illnesses among welfare recipients. And Minnesota Blue Cross and Blue Shield and state officials are suing cigarette manufacturers for allegedly violating the state's antitrust and consumer protection statutes. The Minnesota suit is unusual because it claims the conduct of cigarette manufacturers is not only dangerous but illegal.

Let's keep up the pressure here in Illinois to educate all our patients, especially young people, about the dangers of smoking.

PRESIDENT'S LETTER

The only way to have a friend is to be one

Alan M. Roman, MD



The relationship allowed us to grow separately without growing apart.

Letting go did not occur as easily as writing these words. Just as best friends do not become so overnight, we had been drifting apart for several months. But because few people in life ever qualify as best friends, saying good-bye was far from easy.

On first reflection, we weren't a perfect match. We had children, they did not. They were urban, we suburban. While we liked theater, they preferred movies. We were more athletic, they not as energetic. We had such differing views of the world – until it came to golf.

We met on a golf course, and our friendship came about when we were least looking for it. His unorthodox swing but paraprofessional scores were more than a match for my picture-perfect mechanics, which yielded less-than-reliable results. You can learn carotid surgery, I rationalized, but a person can't ever really learn golf. Nevertheless, with his tutelage and out of enjoyment for both the game and each other, we began to look forward to summer weekend nights. Twilight golf made the grass look greener, and the anticipation of dinner afterward made difficult sand shots easier to master. Off-season we began to travel on short excursions to other courses, our goal being to play the top 100 courses around the country.

As couples, we in time shared more than golf. Like most friends, we shared jokes, meals and experiences. We even jogged together – once! And like best friends, we shared our innermost thoughts and secrets, our aspirations and our fears. We knew what each of us was going through and were genuinely happy when things went well, and supportive when life was not so rosy. They cheered us up and on. We experienced the highest given of friendship – no one had to explain anything.

In time there was a fluid ease to everything we did – the relationship accommodated each of our styles without any of us feeling overwhelmed. We exchanged hugs, free of resentment or rivalries,

before returning to our daily routines and separate existences. In between golf get-togethers, we checked in by phone. The relationship allowed us to grow separately without growing apart.

Along came our first child, later a second. And then came top leadership positions in organized medicine, which severely sliced into our time together. Then came minor disagreements about where to meet for dinner. A final winter trip to a warm climate, where five days of promised sunshine was replaced by rain and frost warnings, made my wife and me think of trading golf clubs for more time with our children.

Frankly, we just decided to let go – primarily because we were tired. Being a good friend is a 24-hour-a-day job. Our lives had become so full that we were unwilling to devote the time and energy to a makeshift friendship.

I think we had dinner together once or twice in the coming weeks and tried to sound interested. That was a signal that our paths were diverging. Our final moments weren't about conversation but rather about shared presence. Small talk was about as small as small talk gets, but in the last moment of togetherness, conversation was beside the point.

Wiser as I've become in the intervening two years, I'm beginning to understand what those times together meant. Even with life's inevitable hurts, we do make a difference to one another. Friendships are easily made but hard to keep. Friendships come from transferring self-concern into concern for others. It's only natural that if you meet the needs of others, your needs will also be met. What you give, you get. What you send out comes back. What you sow, you reap.

One of these days, perhaps we'll again meet for golf, go to dinner and trade stories as the sun sets. But I'll just bet it won't be the same. Friends can be taken for many things but never just for granted.



"Perkins was a plastic surgeon before he joined the park service."

Quotables

"I think we're still going to get it done, even though I hope I'm not naive in believing that."

— **Senate Majority Leader George Mitchell**, speaking on the likelihood of passage of a federal health system reform bill, *Boston Globe*

"I will never run out of amendments."

— **Texas Sen. Phil Gramm**, explaining what he will do to defeat the Mitchell reform bill, *New York Newsday*

"We fool ourselves if we believe the American people want us to create scores of new and expensive programs."

— **Wisconsin Sen. Herb Kohl**, expressing his opposition to the Mitchell bill, *World Today*

"We're still sitting on the fence and have to jump off."

— **Louisiana Sen. John Breaux**, addressing the progress of a bipartisan compromise health system reform plan, *USA Today*

"If we're concerned about health cost-containment, surely we do not want to limit the number of doctors and particularly doctors trained in the high academic centers of the country."

— **New York Sen. Daniel Moynihan**, chairman of the Finance Committee, *Chicago Tribune*

"People have been taken out of the process. We need our patients to be front and center in decision-making. If we put the control with the patients, we will have a more efficient system. Patients would demand cost reform."

— **ISMS Third District Trustee Janis Orlowski, MD**, *Chicago Sun-Times*

"At some point we have to draw on everything we have learned from the experts, from our own constituents and from our own souls, and decide on the actual steps that will solve as much of the problem as we possibly can this year."

— **West Virginia Sen. John D. Rockefeller**, *New York Times*

"We'd all like to stop cost shifting onto certain segments of our society. But it comes down to who's going to pay for it. And anybody who believes that having a huge additional federal government program on top of everything else that we have today is going to solve these problems and reduce costs just doesn't know what they're talking about."

— **Utah Sen. Orrin G. Hatch**, *New York Times*

"It gets very quiet when you start talking about how to pay for it."

— **Nebraska Sen. Bob Kerrey**, *USA Today*

"In the final analysis, I'm going to pull back in, find a quiet corner, think about what's good for our country and vote on the issue as if it were a secret ballot."

— **Pennsylvania Rep. Paul Muhale**, *New York Times*

"The way legislation is made doesn't tend to lend itself to making legislation better."

— **Timothy McBride**, a health care economist at the University of Missouri-St. Louis, *St. Louis Post-Dispatch*

"The legislative process doesn't always produce exactly what you would like, but you have to work with it to get anything at all."

— **William J. Cox**, vice president of the Catholic Health Association, *New York Times*

GUEST EDITORIAL

'Gatekeepers' may be hazardous to your health

By Harry Goldin, MD

This article was originally published in the Los Angeles Times. It is reprinted with the author's permission.

Marla, a 55-year-old woman, had a malignant melanoma removed from her arm several years ago. Later, a red-brown discoloration appeared around the scar. She went to her health maintenance organization physician, who performed biopsies on the site himself rather than send her to a dermatologist, because to do so would have cost money from his own pocket. The lab that he used called the biopsy samples "atypical," but the physician's advice to Marla was only that she "might consider having the lesion removed."

She then switched insurers and became a patient in a different HMO, where the doctors were salaried. The new doctor asked me, a dermatologist, to evaluate the lesion. The melanoma had indeed recurred and was removed right away.

In other cases, I've seen patients badly undertreated for severe itching and patients with communicable skin diseases that went undiagnosed for long periods.

This is a result of a continuing reversal of the basic way that medicine is practiced, from the traditional open-ended "fee for service" to a cost-cutter's invention that coerces doctors in certain types of health maintenance organizations to undertreat patients. In most people's minds, HMOs are staffed by doctors on salary, freed of competitive pressures and able to concentrate on what's best for patients. That model is becoming rare as physicians are increasingly put at personal risk for the cost of treating their patients' illnesses.

To understand this new model requires a descent into jargon. Many doctors who maintain their own offices but participate in an HMO network are known as "at-risk capitated gatekeeper" primary care physicians. Some definitions:

- A gatekeeper physician manages the patient's care by deciding when a test should be obtained and when a specialist should be consulted. A patient who overrules the doctor or seeks a second opinion may get no insurance reimbursement for outside care.
- Capitated, literally per head, means the doctor is paid a set amount per patient per year, no matter what care is necessary or requested.

The physician is at risk because if the patient requires specialist consultations or other outside care, the physician in one way or another can lose money. Various plans use various disincentives against use of specialists.

These plans "work" to hold down costs because the primary care physician has a strong personal financial incentive to restrict care. Employers are increasingly offering only this sort of plan to employees, and more slowly,

Medicare is embracing capitated plans. In my community, almost every primary care physician in private practice and involved in managed care plans is "at risk" to some degree.

A conflict of interest is established between the physician's role as the patient's advocate and the physician's drive to make a profit.

HMO plans with "at-risk capitated gatekeepers" are unethical because they conflict with physicians' inherent responsibility to represent the interests of their patients. They are also unethical because patients are not told that medical decisions may be influenced by outside financial pressures on the physician.

It has been clear for a long time that physicians should not make money from referring patients to other doctors or clinical laboratories. Anti-kickback legislation prohibits doctors from receiving referral payments. The American Medical Association says that physician self-referrals are generally unethical and Medicare will not pay when a physician refers a patient to clinical laboratories in which the physician has a financial interest.

It is a newer issue, but equally clear, that physicians should not withhold patient referrals to make money. Referrals to specialists should be financially neutral. They should be based on the medical needs of the patient.

In the reformed health care system, physicians should compete by the quality and the appropriateness of the care delivered. As the Clinton administration and Congress attempt to provide universal health care coverage and control health care costs, they must also protect the physician's role as the patient's advocate. The administration and Congress should also guarantee consumers' right to know what they are buying. Companies and individuals deserve clear and complete disclosures regarding physician financial incentives before they sign up for insurance plans. Patients enrolled in capitated gatekeeper HMOs have a right to understand the monetary forces that may drive medical decisions. Both the financial incentives to undertreat and withhold care in some types of HMOs and the incentives to overtreat in traditional fee-for-service medicine should be clearly outlined.

Financial incentives, in either direction, are dangerous in medicine and do not promote good patient care.

Dr. Goldin is a dermatologist from Evanston and a member of ISMS.

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GPCI concerns

(Continued from page 1)

proposed changes will have a more negative impact on Illinois physicians than on doctors in any other state, said ISMS Board Chairman Ronald G. Welch, MD, in an Aug. 31 memorandum detailing the meeting.

"We questioned HCFA's use of proxy data, as opposed to actual physician practice data, to measure physicians' practice expenses, and expressed concern about the stability of a methodology that showed such wide swings over a three-year period," Dr. Welch said. He noted, for example, that HCFA used

residential rather than commercial rental rates to calculate the practice expense GPCI.

In addition, Dr. Welch said ISMS "indicated that this lack of stability causes extreme credibility problems and prompts physicians to ask, 'Can work, practice expense and malpractice values really have declined 8.4 percent in Peoria relative to the rest of the country in the last three years?'"

According to Dr. Welch, HCFA responded to ISMS' criticisms of the GPCI refinements in part by citing a U.S. General Accounting Office study validating the use of proxy data. HCFA attributed the wide disparity between the

original GPICs and the changed GPICs to the use of 1990 census data for the new calculations. The first set of GPICs was created using 1980 census data, so the new figures reflect a decade of change, according to HCFA.

"In effect, HCFA said Illinois would have had lower GPICs for the last three years if the 1990 census data had been available when the GPICs were first announced," Dr. Welch said. He added that HCFA further defended the cuts by saying that the relative salaries of highly educated professionals in Illinois did not rise as much as in other states.

HCFA officials also indicated that in most cases physicians' Medicare fees will

not decrease. Instead, the increase in fees will be less than would otherwise have occurred.

The GPCI changes will be phased in 50 percent per year over two years. Also affecting reimbursement will be regular fee schedule updates — with the next one scheduled for Jan. 1, 1995 — and RBRVS implementation.

But Dr. Welch said ISMS remains "deeply skeptical" about the use of proxy data. The Society submitted formal comments to HCFA outlining Illinois physicians' continuing concerns about the proposed GPCI changes, Dr. Welch said. In the comments, which were prepared after the Society's meeting with HCFA officials, ISMS recommended that physician-specific data be collected and used for the work and practice expense GPICs. "This includes the actual rental costs incurred by physicians, the actual costs associated with nonphysician employees, including benefits, the actual costs for other 'overhead' and supplies and the actual value of physicians' time, [such as] physician incomes. ISMS recognizes that the GPICs are based on relative costs. Nonetheless, the use of better data will make the Medicare fee schedule more reliable, accurate and defensible."

Dr. Welch concluded by saying that HCFA promised to provide ISMS with data related to the GPCI formula and that ISMS will continue to review those data to try to identify other methodological problems. The Society will also contact medical societies in states facing GPCI cuts to see whether they have found flaws in the data or in HCFA's methodology. Dr. Welch encouraged input from county medical societies in Illinois, since HCFA agreed to review any data ISMS presents that show errors in individual areas. ■

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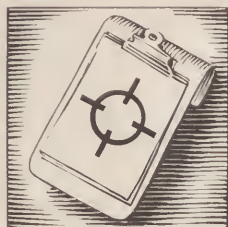


UIC resumes several transplant procedures

[CHICAGO] The cardiothoracic transplant team at the University of Illinois at Chicago Medical Center has received approval from the United Network for Organ Sharing to perform heart, lung and heart-lung transplants. The approval is significant because it reactivates the medical center's transplant program, which once performed up to 20 transplants per year but ceased in 1989 during a staff transition period, UIC officials said. The United Network for Organ Sharing is the federally designated organ procurement and allocation system for the United States.

According to the medical center, Illinois and Northwest Indiana patients with otherwise untreatable heart and lung disease who are waiting for organ transplants will benefit from the program. "Our cardiothoracic transplant program can work with other transplant programs at the medical center to perform multiple transplants such as heart-lung or heart-liver," said James Houck, MD, director of thoracic organ transplants. "We are one of the few medical centers in the area with this capability."

Currently, in northern Illinois and northwest Indiana, 110 patients are waiting for hearts and six for lungs. Several of those patients are on UIC's cardiothoracic transplant waiting list, according to the Regional Organ Bank of Illinois. ■



Case in Point
returns in the
Sept. 23 issue

ISMIE Update

Watch for
coverage of
liability
issues for
primary care
physicians in
managed care
in your next
issue

MALPRACTICE ROUNDUP

Parents can sue for costs of raising child

An Oregon couple sued a physician and a hospital for the expenses of raising their third child, according to a case summary in Medical Malpractice Law & Strategy. The woman's physician failed to perform a requested tubal ligation after the cesarean delivery of their second child.

In *Zehr vs. Haugen*, the parents claimed the defendants were negligent in failing to perform a tubal ligation and alleged a breach of contract claim against the physician. After finding that the plaintiffs had not presented sufficient legal allegations to support negligence and breach of contract claims, the trial court dismissed allegations supporting economic damages to cover the expenses of raising and educating the child and granted the defendants' motions to dismiss.

On appeal, however, the Oregon Supreme Court noted that the trial court had failed to consider whether the alleged types of economic damages were recoverable under the asserted claims, according to the case summary.

The defendants argued during appeal that such damages were not recoverable because legally the birth of a healthy child could not be considered harm and the amount of alleged damages for raising and educating a child are too speculative to permit recovery. But the high court ruled as irrelevant the assertion that some individuals might consider a child's birth beneficial and said the parents should not be barred from claiming they were harmed by the baby's birth. The court also ruled that a jury must decide whether the damages were too speculative and that the court's only function was to decide whether the plaintiffs were entitled to specify alleged damages in their complaint, the summary said.

The court did not discuss its rationale for ruling that the birth of a healthy child could be considered a legal injury or address whether the birth of a normal child could be used to mitigate or offset damages claimed in these kinds of cases, according to the case summary. ■

Hospital negligent in drug toxicity suit

An Illinois appellate court affirmed a trial jury's \$4-million verdict against a hospital for negligence in treating a woman who died as an inpatient of the hospital's detoxification program. The patient was dependent on propoxyphene napsylate and acetaminophen and admitted herself to the hospital voluntarily, according to a summary of *Harrington vs. Rush-Presbyterian-St. Luke's* published in the Malpractice Reporter.

She became groggy after the first day or two in the hospital, was constantly falling asleep and unable to converse after five days, suffered severe headaches and was incoherent on the sixth day and died after just one week in the hospital, the summary noted. The autopsy revealed that she died from "combined drug toxicity" resulting from an overload of drugs, most notably propoxyphene napsylate and acetaminophen.

The case revolved around whether hospital personnel had met their obligations in monitoring the patient. Evidence showed that nurses had failed to administer medications at two required intervals and that no one had checked on the patient for at least six or seven hours, during which time rigor mortis had set in, according to the article. The plaintiff's expert said the woman could have lived if nurses had identified her condition and administered naloxone hydrochloride. ■

State study shows liability costs soaring

DATA: The price of defending claims is increasing dramatically. By Anna Chapman

[SPRINGFIELD] As the trial lawyers' lobby weighs in heavily on the federal reform debate by attempting to block efforts at meaningful tort reform, a recently released state insurance study revealed that indemnity payments and defense costs for lawsuits with and without merit have increased dramatically since 1980. The 1994 Medical Malpractice Claims Study was prepared by the Illinois Department of Insurance, as directed by the state's insurance code. The report is based on data gathered from closed claims filed with the department between 1980 and 1992.

The study shows that to defend policyholders in lawsuits without merit, the attorneys' fees paid by medical malpractice insurers are increasing, said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors.

"Although physicians will be dismayed to hear these numbers, the report does illustrate that significant tort reform,

especially caps on noneconomic damage awards, must be enacted in Illinois," Dr. Jensen said. "In a majority of cases, insurers are being forced to pay to defend frivolous claims that never should have been filed. The result is increased health care costs for everyone."

More than half the claims closed in 1992 had no indemnity payments, according to the study. However, the average payment to defense counsel on those claims without indemnity was \$10,705. Attorney fees for claims closed with indemnity payments and defense costs averaged \$25,637.

The number of malpractice claims also increased substantially between 1980 and 1992, the study revealed. In 1992,

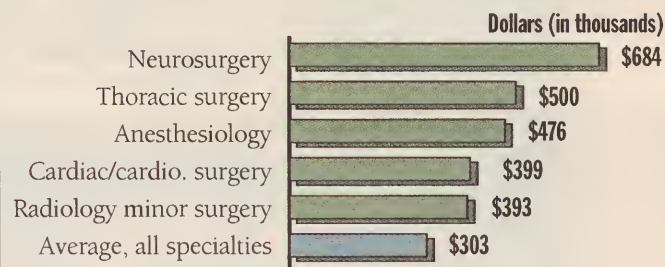
3,494 claims were closed in Illinois, compared with only 620 in 1980. Of those 620 claims, 213 were closed without indemnity payments but incurred defense fees, which averaged \$3,101. For the claims that closed with indemnity payments and that included defense costs, the average payment to defense counsel was only \$4,756.

"The study reveals that the cost of defending a claim that was eventually resolved without payment increased more than 245 percent from 1980 to 1992," Dr. Jensen said. "It also shows that the total cost of defending claims against Illinois physicians was nearly \$35 million in 1992. That should send a clear signal to the Illinois legislature that frivolous lawsuits must be curtailed."

OF THE 29,055 CLAIMS closed between 1980 and 1992, more than 25 percent had indemnity payments, and the total indemnity for those claims was \$1.6 billion, according to the study. Of that total, 40 percent was paid out in the last three

(Continued on page 8)

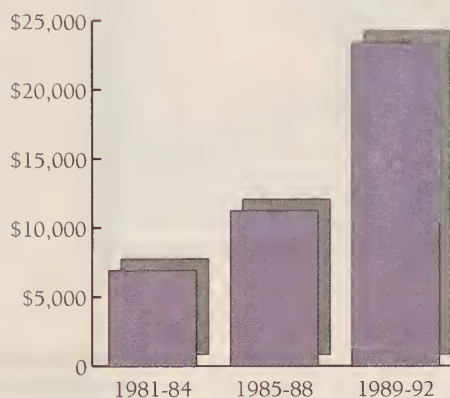
Specialties with the highest per-claim average indemnity, 1988-92



Source: Illinois Department of Insurance,
1994 Medical Malpractice Claims Study

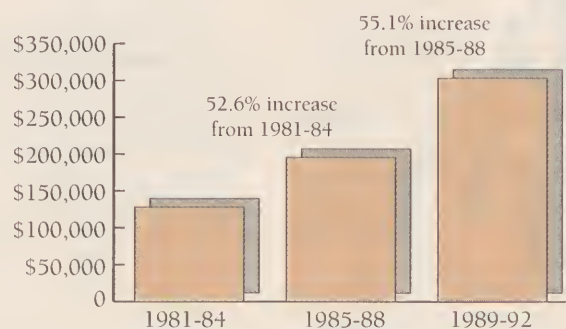
Average pay to defense counsel

Claims with indemnity, 1981-92



Source: Illinois Department of Insurance,
1994 Medical Malpractice Claims Study

Average indemnity, 1981-92



Source: Illinois Department of Insurance, 1994 Medical Malpractice Claims Study

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

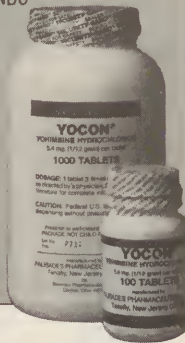
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Liability costs

(Continued from page 7)

years of the study period. Indemnity paid on Illinois malpractice claims was \$11.1 million in 1980. By 1992, it had reached \$278.7 million.

To show the variance in the number of claims and the indemnity paid per specialty, the data were reported for the 1980-92 period and broken down into three four-year segments — 1981 to 1984, 1985 to 1988, and 1989 to 1992. For the entire period, the specialties for which claims with indemnity payments were highest were the following:

- Ob/Gyn surgery, with 858;
- General surgery, with 755; and
- Family/general practice surgery, with 700.

The average indemnity payment per claim also increased markedly for all specialties, according to the study. For example, the average indemnity payment for thoracic surgery claims rose 70.2 percent between the study periods of 1981-84 and 1985-88. Then during 1989-92, the average payment skyrocket-

ed by 227 percent. The cumulative increase for thoracic surgery indemnity payments between the study periods 1981-84 and 1989-92 was 456.5 percent, jumping from an average of almost \$90,000 to about \$500,000. Claims against neurosurgeons showed the second highest increase in average payment at 408.1 percent.

According to comments accompanying the study results, the average payment on medical malpractice claims is "increasing at an alarming rate."

"These study results re-emphasize the need for caps," Dr. Jensen concluded. "Without such tort reform, the rise in indemnity payments and attorneys' fees will continue. Physicians support payments to cover legitimate medical expenses and other economic losses for those patients truly injured through medical malpractice.

But it is not possible to put a price tag on intangible losses such as pain and suffering. That's why we think a reasonable cap must be put in place. Without it, the liability climate will never stabilize."

Specialties with the highest number of claims with indemnity, 1981-92:

• Ob/Gyn surgery	858
• General surgery	755
• Family/general practice surgery	700
• Orthopedic surgery	617
• Internal medicine, no surgery	503

Source: Illinois Department of Insurance, 1994 Medical Malpractice Claims Study

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MEDICINE AND THE ARTS

Theater as therapy

A physician mixes creative expression with the practice of medicine.

BY RICK PASZKIET

For Shakespeare, the world was a stage. For Riaz Baber, MD, and his co-workers at the Mercy Center for Health Care Services in Aurora, the stage is a place to express creativity, explore emotions and strengthen relationships. The theater is more than just props, lights and scenery; it's a venue for artistic and emotional growth.

"Not only does the theater provide me with a creative release, but it also educates me about my own profession because most plays concentrate on the complexities of human behavior," said Dr. Baber, a psychiatrist with Fox Valley Psychiatric Services in Aurora. "The theater analyzes characters and their actions. In a way, the theater, like the psychiatrist, probes a person for a better understanding of his or her motives. You're trying to answer the same basic question — how do people express themselves?"

Although Dr. Baber has no formal theatrical training, he studied film and video at Columbia College in Chicago. His introduction to the stage began in earnest when he helped form a community theater group based in Aurora.

CALLED PROSCENIUM ONE, the production group is composed of local residents who love the theater. Since 1991, the group has produced such plays as "Death of a Salesman," "ER" and "Barefoot in the Park."

"My main interest in the theater is directing," said Dr. Baber. "I enjoy working with actors and watching the whole production evolve and come together. It's exciting."

The primary goal of Proscenium One is modest: to make sure the entire cast and crew have fun, according to Dr. Baber. "Putting on a play allows group members to relax and enjoy themselves while still sharpening their theatrical skills and talents."

Proceeds from Proscenium One productions are typically donated to Mercy Center. Founded in 1911, Mercy Center is one of

the largest providers of psychiatric and addiction services in Illinois.

Over the years, Proscenium One has developed strong ties with Mercy Center. Besides staging its plays in Mercy Center's auditorium, many of Proscenium One's actors and stagehands are Mercy Center staff

(Continued on page 10)



David Lee Csicsko

Theater as therapy

(Continued from page 9)

members.

"More than half the cast comes from Mercy Center. For me, this interaction with the staff is a wonderful bonus in being a part of Proscenium One," explained Dr. Baber. "During the production of a play, a natural camaraderie develops between the entire group. We become a team. This benefits everyone because we're then able to form deeper working relationships with one another on and off the stage."

Proscenium One's fall production, Dale Wasserman's "One Flew Over the Cuckoo's Nest," seems tailor-made for Dr. Baber. After all, the play focuses on a psychiatric ward. Specifically, it deals with the conflict between an authoritarian head nurse and her most rebellious patient.

"To an extent, I can relate to the play's setting and characters, as well as to its exploration of psychiatric issues," said Dr. Baber, who will direct the production. "Also, there are several actors from the adolescent program of Mercy's Behavioral Health Services performing in this play. They're able to use their own day-to-day insights and experiences and adapt them to their roles."

Directing a play is time-consuming, though. It can also be emotionally draining and require a great deal of patience. But Dr. Baber said he believes that in spite of the demands, Proscenium One has taught him how to work more effec-

tively with people.

Dr. Baber's theater involvement extends beyond his contribution to Proscenium One. Last year, with the help of Susan Kinsman Oatman, RN, he established Teens Tell Theatre, a theater group composed of high school students from Chicago's western suburbs.

"This community has been very good to me and my family," said Dr. Baber. "Forming and then training the teen theater group was an opportunity for me to give something back to my community and show my appreciation."

The impetus for Teens Tell Theatre began when Dr. Baber attended a conference on adolescent psychiatry in San Diego. The conference emphasized the benefits of high school students' involvement in programs, such as theater groups, that provide an outlet for expressing feelings and concerns.

"The idea behind Teens Tell Theatre is to present social issues in a theatrical form," said Dr. Baber. "Through the theater, teen-agers can use their creativity to examine issues that are important to them and their peers. It helps students resolve problems through self-expression."

More than 65 high school students participate in Teens Tell Theatre. They are active in every aspect of play production, including writing the scripts, acting and providing backstage support.

"The students involved in Teens Tell Theatre represent a cross section of our youth. They are not just the 'stars' of the high schools," said Oatman, who is the

systems improvement coordinator at Mercy Center Behavioral Health Services. "We have honor students who have studied abroad, as well as troubled teens from broken homes. But this diversity makes the group more vibrant and willing to discuss some hard subjects."

The theater group gives students a chance to get the word out to their peers about such serious issues as AIDS, drug abuse, gangs, domestic violence and the pressures that go along with being a teen-ager, Oatman said.

*This group is about
communicating.*

*We're sending positive
messages to people*

*our own age
about concerns
we all share.*

"The most important benefit I see from this program is that it gives teen-agers a forum in which to participate and contribute to their own teen world," Oatman added. "Teens Tell Theatre guides them along as they develop their

own special identities."

Mary O'Brien, a Batavia High School sophomore, performs in the group and, in the last production, portrayed a teen-ager coping with the trauma of teen pregnancy. "When we first started performing this scene, there was a lot of nervous laughter from the audience," she said. "But after a while, it became extremely quiet as the audience became involved with the characters and their problems."

Teens Tell Theatre reaches students because it presents issues through a teen perspective, O'Brien said. "This group is about communicating. We're sending positive messages to people our own age about concerns we all share."

The group performs at local high schools and teen centers. After each performance, there's a question-and-answer session in which the audience has a chance to respond to the issues raised in the production.

So far, Teens Tell Theatre has been enthusiastically received by the students involved and by their teachers and parents. Dr. Baber said the group shows teen-agers the community's commitment to understanding and helping them.

"My involvement in Teens Tell Theatre has made me even more aware of the problems that teen-agers face on a daily basis," he said. "Working with the students in this group has been one of the most rewarding experiences of my career. It has allowed me to develop excellent relationships with teen-agers in an informal setting." ■

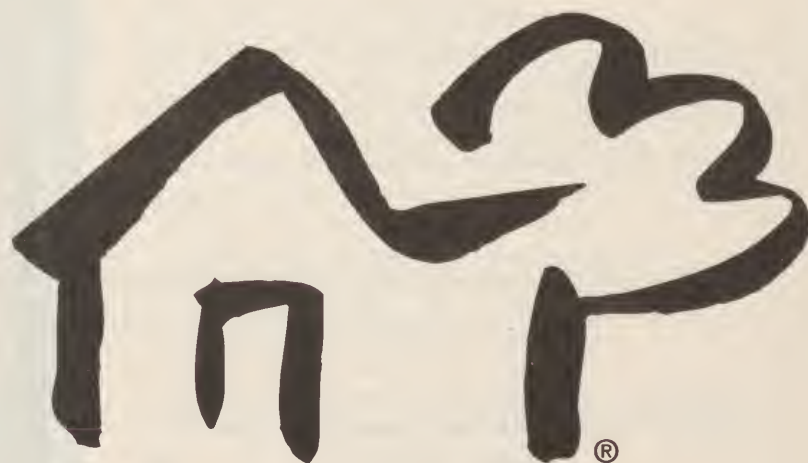
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Self-referral

(Continued from page 1)

"The law is very, very broad and makes it incumbent upon physicians to examine their relationships with all health-care-related entities," said Tom Conley, an attorney at Burditt & Radzius in Chicago. "In trying to close potential loopholes [for fraud and abuse], the new law has encompassed many innocent relationships. Before, the government was looking for intent. It wanted to see that physicians intended to get kickbacks. Now, the mere existence of a financial relationship can create violations." He stressed that physicians must also scrutinize the law's definitions of financial relationships and immediate family members. Its definition of immediate family member, for example, extends to adoptive parents, stepparents, in-laws, grandparents and grandchildren.

Conley said the federal law considers any ownership or investment interest in an entity through equity or debt and any compensation arrangement between a physician or family member and an entity to be a financial relationship. "It can include any contractual or compensation arrangement whereby goods or services would exchange hands."

In addition, physicians must examine the chain of referral. "Physicians have to track where their investments are investing," Conley noted. "If a doctor invests in a small company that's not publicly traded and that company happens to invest in a clinical lab, the doctor's referral to that lab would be prohibited. And if that doctor's grandfather invests in the small company that invests in the lab, the doctor still can't refer patients to that lab."

"[The law] has frightening consequences," Conley continued. Any physician who violates the federal law, for example, is subject to a civil monetary penalty of up to \$100,000 per violation and may be excluded from participation in the Medicare program, according to the SIU Law Journal article.

THE SUMMARY NOTED exceptions to the federal law, including ownership or compensation arrangements in rural facilities that provide substantially all services to rural residents; remuneration by a hospital to a physician if such compensation does not relate to the provision of designated health services; physician services provided by or under the personal supervision of another physician in the same group practice as the referring physician; investments in a publicly traded company listed on a recognized stock exchange with at least \$75 million in stockholder equity; and rental of office space or equipment on fair market terms unrelated to referrals. This list is not inclusive, and each exception depends on certain circumstances.

Physicians must remain wary of all financial relationships, Conley said. "Many misperceive what the exceptions allow, so it's important to proceed with caution. For example, physicians trying to take advantage of the rural provider exception must determine where the bulk of their patients reside, since the majority of designated services must be furnished to individuals residing in rural areas. The federal government is concerned about physicians who settle in rural areas and then treat patients in nearby metropolitan areas."

In addition, the hospital remuneration exception must be examined closely, since segregating the services included in

the exception could be more difficult than the law's language implies. "A service may end up being related to the designated services and thus take the physician out of the hospital compensation exception," Conley said.

Although the federal prohibitions are significant for Illinois physicians, Conley said physicians must consider them

along with bans in force through the Illinois Health Care Worker Self-Referral Act, which was signed into law in 1992. The act applies to referrals for health services made on or after Jan. 1, 1993. However, if health care workers acquired an investment interest before July 1, 1992, the state law does not ban referrals for health services until Jan. 1,

1996. "Illinois physicians can't read [the federal law] in a vacuum, because the Illinois act in many respects is even broader. Most health care workers will have to comply with the most restrictive parts of both laws," he said.

Like the federal law, the Illinois act prohibits physicians from referring (Continued on page 12)

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Self-referral

(Continued from page 11)

patients to an entity outside their office or group practice if they or an immediate family member – defined in Illinois as a parent, spouse, child or child's spouse – invests in that entity. The act mimics federal law by failing to extend the ban to referrals to facilities in which doctors themselves treat the referred patients. And the state law does not prohibit referrals to other physicians within a group practice, Conley said.

The Illinois law is more far-reaching than the federal law, however, since it bans inappropriate referrals for all

patients, not just Medicare and Medicaid participants; applies to all health care workers as defined by the statute, not just physicians; and includes all services, not just specific services as designated in the federal law.

In addition, the publicly traded entity exception is narrower in Illinois, Conley noted. "In Illinois, the entity must have net assets of at least \$30 million related to the furnishing of health services, and a physician's or family member's investment interest can't exceed one-half of 1 percent of the entity's total equity. So, if a doctor's dad is a major shareholder in a company [that provides health services], for example,

that doctor could be out of luck."

The state law also excludes the type of rental exception found in the expanded federal law, Conley said. "In Illinois, if a health care worker owns a building and leases space to an entity, referral to the tenant may be considered a violation of the act." Conley noted that the exceptions to the state and federal referral bans are separate from the safe harbors identified in the federal Medicare and Medicaid anti-kickback statute.

Because the "prohibitions are very broad and exceptions very narrow" in the state and federal law, Conley advised physicians to examine all their financial relationships carefully to ensure compli-

ance. "[Physicians] should practice preventive regulatory compliance."

Conley recommended that health care workers consult an attorney to review any financial relationships they think may violate the laws, because of the complex nature of the prohibitions and exceptions and the severe penalties for violations. Potential consequences for violators of the state statute are license suspension or revocation, criminal prosecution and administrative fines of up to \$10,000 per infraction, Conley said.

Physicians may contact an attorney with expertise in this area by calling the ISMS Lawyer Referral Network at (800) MD-ASIST. ■

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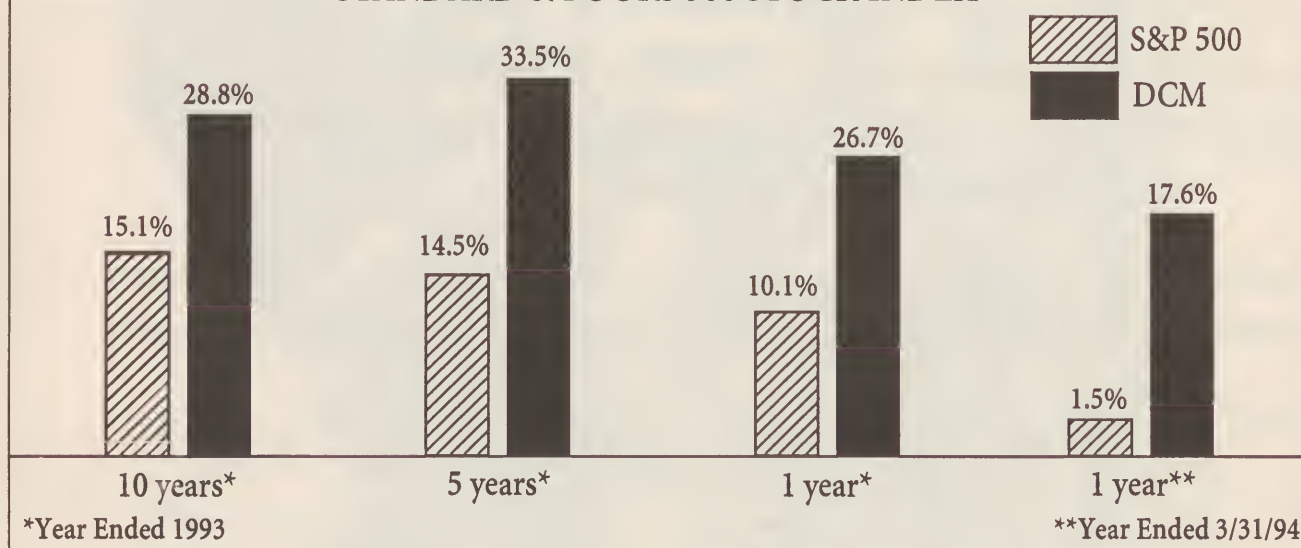
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MEMBERS IN THE NEWS

In recognition of his outstanding record of community service, Stanley Rousonelos, MD, a retired Joliet general practitioner, received the 1994 Man of the Year award from the Joliet chapter of UNICO, an Italian social service organization. Dr. Rousonelos was honored for his contribution of time and talent as a volunteer physician at the Will-Grundy Medical Clinic. He has served on ISMS' Council on Public Relations and Membership Services since 1989.

The annual award is presented to individuals who have "gone beyond the call of duty to help the community," said UNICO member Marilyn Tarizzo. Award winners need not be members of UNICO, which stands for unity, neighborliness, integrity, charity and opportunity, but they must be actively involved in volunteer activities.

The medical staff of Our Lady of the Resurrection Medical Center in Chicago recently elected officers for the 1994-96 term. The new president is Raj Rajasekhar, MD, a board-certified internist and endocrinologist and 16-year member of the hospital's medical staff.

Other officers are vice president Richard Shermer, MD, a board-certified orthopedic surgeon and 17-year member of the medical staff; secretary Farid Saheb, MD, a board-certified internist and nephrologist and 18-year medical staff member; and treasurer Hrach Hitik, MD, a board-certified family medicine specialist who has been on the medical staff for 30 years.

The American College of Physician Executives has awarded membership to Hugo Velarde, MD, chairman of the department of family practice at St. Elizabeth's Hospital in Chicago. The college, with more than 9,000 physicians among its members, is the nation's only educational and professional organization for physicians in medical management.

Dr. Velarde is a board-certified physician who specializes in family practice. In addition to his position at St. Elizabeth's, Dr. Velarde works at St. Mary of Nazareth Medical Center in Chicago. He has worked at both institutions for 20 years. ■

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Home-based program

(Continued from page 1)

and other issues. "Teaching is accepted better in the home than on the first day after delivery," Dr. Bilinsky explained. "But if you keep the mothers in the hospital because the parents feel unsure of themselves, then it won't be covered. We can't keep them for teaching purposes."

It's difficult to teach the mother everything she needs to know in the 24 hours she's in the hospital, Streb said. "First of all, she's too tired. Her physical capabilities are not conducive to learning, nor are her mental capabilities, because she's still in the taking-in phase. This is not the teachable, reachable moment."

By seeing the patients in their homes before and after delivery, nurses are able to provide ongoing parent education. "If they get information prenatally, a brief review after delivery is far less intense than starting at the beginning with teaching," Streb explained. However, only about 10 percent of patients attend the free prenatal classes offered at the hospital, said Diane Loscher, RN, supervisor of home health services. "We're hoping to increase that number through our 30-week visits," Loscher said.

During the 30-week visit, nurses instruct expectant mothers about the signs and symptoms of labor, relaxation techniques, the choice of a physician for the baby and available support systems and community services, Loscher noted. Patients are often unaware of these services, she said, adding that program referrals have helped several women find

Bilinsky said. If the nurses discover any problems, they contact the infant's physician, she explained. "If the problem is jaundice or poor weight gain, they call from the home."

"We can only work under physicians' orders," Loscher stressed. If a test is needed, such as a bilirubin to confirm jaundice, the nurses must obtain an order from a physician. Physicians also receive copies of all assessments completed by home health nurses, Loscher said. "Even if they're normal, [physicians] still get a copy."

"Most of the physicians have been very supportive of the program, and most refer their patients," she added. ■



Photo courtesy of St. John's Hospital

As part of St. John's Hospital's Beautiful Beginnings Come Home program in Springfield, nurse Julie Hurrelbrink (left) examines new mom Christie Johnson and her infant daughter, Katie, three days after they were discharged from the hospital. Through the program, nurses see patients in their homes to provide parent education and patient assessments.

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necessary furnishings like cribs through charitable organizations in Springfield.

The nurses also preregister women for their hospital stay and gather preliminary information for birth certificates. "The more we can get done prenatally, the less there is for the mother to concentrate on [in the hospital]. She can just focus on the few hours of rest she can get before she goes home," Streb said.

When the nurses visit the mother and baby at home after delivery, they complete an overall assessment of both patients, Loscher said. For the mother, this includes reviewing proper breast-feeding techniques; evaluating uterus size; noting temperature, blood pressure, bowel movements and difficulty urinating; and checking on the healing of episiotomies or cesarean sections. "For the baby, we do a head-to-toe [examination] - weight, skin color, vital signs, hydration and respiration," Streb said.

The home nurses often detect signs of physiologic jaundice, which takes two to three days to appear, Streb said. Previously, health care providers at the hospital listed the signs of jaundice for new mothers and hoped they would report the signs to the baby's doctor. "But it's not always easy for a layperson to detect," she said. Now, through the program, "if there is a question, the nurse can do some laboratory tests and bring them back to the hospital," Streb added.

"The program has been a great help with moderately elevated jaundice," Dr.

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State acts on vaccine plan

PREVENTION: Eligible children will receive free shots. BY ANNA CHAPMAN

[SPRINGFIELD] Despite well-publicized federal delays, the Illinois Department of Public Health is preparing to implement the Vaccines for Children program and will soon mail enrollment kits to all Illinois physicians, said Richard Galati, a public health administrator in the department's immunization section. Through the program, participating physicians will receive childhood vaccines to deliver free to eligible children. It is scheduled to begin Oct. 1, but federal-level snags threaten to delay state implementation, Galati said.

IDPH is currently seeking support and final comment on the program from ISMS, the Illinois chapter of the American Academy of Pediatricians and the Illinois Academy of Family Physicians. The \$460-million program is designed to boost childhood immunization rates, especially for children under age 2, Galati said.

Under the program, children eligible to receive free immunizations include those who are enrolled in Medicaid, lack health insurance and are American Indian or Alaskan natives, Galati said. Children who have private insurance that does not cover immuniza-

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ISMS briefs members on the changing health system reform debate

UPDATES: Society leadership urges grass-roots physicians to communicate with lawmakers. BY JANICE ROSENBERG

[CREST HILL] To help ISMS members keep abreast of the health system reform debate, the Society is holding physician briefings at county medical society meetings around the state. In Winnebago, St. Clair, DuPage and Will-Grundy counties, among others, ISMS physician leaders have shared information about the status of the debate and offered tips about how physicians can influence the legislative process.

"Both the U.S. House and Senate are on the verge of making key health system reform decisions," said ISMS 12th District Trustee William Kobler, MD, at an Aug. 24 member briefing in Will-Grundy County. "We, as physicians, need to have control over the practice

of medicine to assure that future patients receive high-quality and appropriate medical services."

"The challenge immediately before us is like no challenge we've ever faced before," added ISMS Third District Trustee Dennis Brown, MD, who also spoke at the Will-Grundy briefing. "That means we need to meet it head-on, with each and every one of you and each and every one of your colleagues actively involved."

Through its Washington Presence program, ISMS has laid the groundwork for addressing the challenges posed by health system reform, Dr. Brown said. The program was launched in 1991 to capitalize on strong ties with policy-makers in Washing-



Dr. Brown

ton. Its main objective is to persuade as many members of the Illinois congressional delegation as possible to vote for a health system reform plan that addresses the concerns of Illinois physicians and promotes

(Continued on page 19)

Doctors, hospitals prepare for credentialing law

IHA seminar outlines the legislation's provisions for Illinois hospitals

BY ANNA CHAPMAN

[CHICAGO] Most Illinois hospitals will have to make changes in policy and medical staff bylaws to prepare for compliance with the Jan. 1 enactment of S.B. 398, legislation focusing on economic credentialing, according to Illinois Hospital Association representatives presenting an Aug. 24 seminar. The measure passed the Illinois legislature this spring and, as this issue of Illinois Medicine went to press, awaited the governor's signature.

The definition of economic credentialing is subjective, said IHA Associate General Counsel Thaddeus Nodzinski. "One person's economic factor is another person's quality indicator. But the mere perception among physicians that they are being economically credentialed is a problem for hospitals."

Michael Callahan, a partner with the Chicago law firm of Katten, Muchin & Zavis, reviewed the legislation, section by section. The bill defines

Physicians should take an active role in changing medical staff bylaws

BY RACHEL BROWN

[CHICAGO] As this issue of Illinois Medicine went to press, Gov. Jim Edgar was expected to sign S.B. 398. At that time, Illinois will become the first state to enact legislation that protects physicians from hospitals' economic credentialing practices, ISMS Board Chairman Ronald G. Welch, MD, said in a letter to Society members.

"On behalf of our 18,000 members, ISMS is proud to have led the fight for physician due process protections against economic credentialing," Dr. Welch said. "We appreciate Gov. Edgar's strong support to date as well as that of our General Assembly. We hope you will use this new law fully by making it a part of the hospital organizational bylaws governing your practice of medicine."

(Continued on page 12)



Matt Ferguson

GOV. JIM EDGAR accepts an endorsement for a second term from the political action committee of the Illinois Statewide School Management Alliance.



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HMO brochure results in \$26-million damage award

MANAGED CARE: An Idaho woman wins a lawsuit against an HMO for alleged misrepresentation of benefits. BY ANNA CHAPMAN

[BOISE, IDAHO] On July 20, an Idaho jury awarded more than \$26 million in damages to a plaintiff who claimed her health insurance company improperly denied coverage for her husband's liver transplant. According to a transcript of the verdict, the jury found that the HMO and its parent company committed fraud by listing transplant coverage in a brochure of covered services it distributed to prospective insureds, including the plaintiff. Although organ transplants were listed as a covered service in the pamphlet, the defendants claimed that the plaintiff's contract with the company did not cover the service.

"This is a simple case where the insurance company in its brochure described coverage in a broader fashion than in the plan," said the plaintiff's attorney Jim Risch. In general contract law, the contract usually prevails, he said. But in cases involving brochures and contracts, juries often find that individuals might not reasonably be expected to read the contract, he added.

The jury in *Warne vs. Lincoln National* awarded Maria Warne \$320,000 to cover the cost of her husband's trans-

plant, \$1.5 million for pain and suffering and \$25 million in punitive damages, according to the verdict. The jury found that the defendant-HMO "intentionally breach[ed] its duty of good faith and fair dealing" in handling the claim. In addition, the jury found "clear and convincing" evidence of fraud.

In her complaint, the plaintiff stated that her husband, George Warne, faced "imminent death" in September 1990 unless he received a liver transplant. The HMO refused to pay the claim. Although Warne ultimately received and paid for the transplant, the Warnes suffered "extreme emotional distress" as a result of the experience, the complaint said.

In its benefits and services brochure, the HMO stated that it would pay all but 5 percent for organ transplants performed at a "designated organ facility." But in its answer to the complaint, the parent company denied that the service was covered under the Warnes' contract.

"We disagree with the jury verdict," said Grant Burgoyne, a defense attorney for Lincoln National. "We do plan to file all posttrial motions, and, if necessary, we will appeal." ■

Talk to Medicaid patients now

At the end of the 1994 legislative session, the General Assembly passed Gov. Jim Edgar's proposal to curb Medicaid costs by adopting a managed care approach in the state's Medicaid system. The plan is scheduled for implementation by April 1, 1995. It will apply to Cook County and possibly Downstate as well, depending on whether capitated managed care systems there contract with the Illinois Department of Public Aid.

In early September, IDPA informed ISMS representatives that most current Medicaid recipients will be required to choose a primary care provider between mid-December and mid-January. So physicians should begin taking steps now to help retain their fee-for-service Medicaid patients. Recipients who fail to choose a specific fee-for-service gatekeeper or capitated managed care system will automatically be defaulted into the latter. They will then have 30 days to change their decision.

In preparation for the new plan, primary care physicians should identify and talk to each Medicaid patient about the decision he or she will make. Patients will be able to choose a primary care provider who will act as a gatekeeper, a Federally Qualified Health Center, an HMO or a Medicaid managed care community network. Physicians who want to maintain existing relationships with Medicaid patients should communicate the value of their current doctor-patient relationship. They should also be prepared to help recipients — who will receive a mailing

from IDPA — communicate their choice to the department.

According to IDPA, Medicaid recipients will be exempt from the managed care program if they

- Reside in nursing facilities or intermediate care facilities for the mentally retarded,
- Are eligible for only a past month,
- Have a spend-down,
- Are enrolled in Medicare,
- Are eligible only through the Medicaid presumptive eligibility program,
- Are not citizens of the United States and are receiving only emergency medical assistance,
- Are children who are technology-dependent or
- Reside in facilities operated by the Department of Mental Health and Developmental Disabilities or the Department of Corrections.

Except for treatment of patients in these categories, specialists will be paid only if care is authorized by a gatekeeper. To facilitate future referrals, specialists should begin discussions now to formalize their relationships with primary care physicians. Other options for specialists will include contracting with a participating HMO, FQHC, rural health center or managed care community network.

Illinois Medicine will provide more details of these changes as they become available. Physicians who have questions about the plan may call the health care finance division at (800) 782-ISMS or (312) 782-1654, ext. 1171. ■



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State releases top causes of teen hospitalizations

[SPRINGFIELD] Childbirth is the leading cause of hospitalization for 12-to-20-year-old Illinois women, according to a study of 1992 hospital discharges released by the Illinois Health Care Cost Containment Council in August. Mental health disorders, which caused the most hospital admissions among male adolescents, were the No. 2 cause of hospitalization for female teens, the study said.

"This information should be of concern to everyone," said John Noak, the council's executive director. "The data suggest that teen-age pregnancy is still very much with us, and it is having a dramatic and costly impact on our health care delivery system."

Noak added that the study results "suggest a recent alarming trend involving the medicalization of social problems. Too often, social problems of a broad-based nature, such as poverty or family instability, are ignored, and the

casualties of this neglect then are turned over to the medical system to be 'cured.' The end result is an increasingly growing cost in dollars for all of us and misery for the young and their families."

Underscoring the high cost of teen hospitalizations related to mental health disorders, the study revealed an average charge of \$15,376 per stay for females and more than \$16,000 per stay for males.

Depressive neuroses, digestive disorders in 12-to-17-year-olds and poisoning and the toxic effects of drugs in 12-to-17-year-olds also ranked among the top 10 reasons young females were hospitalized, according to the study. Depressive neuroses, childhood mental disorders and neuroses without depression joined psychoses on the top 10 list for male teen hospitalizations, the council said.

Alcohol and drug abuse or dependency ranked 11th on the list of reasons for hospitalization of adolescent males, according to the study. No information is available to compare Illinois with national figures, the council said. ■

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Congressional candidates offer views on reform

With the general election just over a month away, Illinois Medicine is highlighting key races. In this issue, the focus is on several congressional contests. Watch for continuing coverage in upcoming issues. The symbol (I) denotes incumbents.

Third Congressional District

Jim Nalepa (R)

Should universal access to health care be immediate or phased in? Phased in. As far as we know, everyone currently has access to health care. Coverage is a different story.

System I support: Consumer-based

Position on employer mandates: Oppose. If done right, reform should not be something we need to throw money at.

How the current system should be reformed: I support increasing access for the uninsured through insurance reforms such as purchasing and risk pools, ensuring tax fairness by enabling self-

employed and unemployed individuals to deduct their health insurance costs, reducing paperwork through the use of electronic and universal claim forms, providing consumers with more control

over health care decisions by switching existing tax exclusions for employer-provided health insurance to tax credits or medical savings accounts.

Federal bills supported: None. The Mitchell and Gephardt bills move in the wrong direction.

Position on caps on noneconomic damages: Support, but the amount is subject to discussion

Position on antitrust relief for physicians: Support, because it would give more flexibility to doctors and hospitals. Laws designed to prevent unfair collusion have the unintended effect of creating unnecessary duplication, such as preventing several hospitals in a city from sharing expensive imaging technology.

Suggestions for improving Illinois' health care system: Because rapidly rising Medicaid costs are driving many states' budgets into deficit, I advocate giving the states greater flexibility to tailor their Medicaid programs to control rapidly rising costs and expand coverage when possible. We should permit states to provide Medicaid vouchers that would give beneficiaries greater control of their health dollars.

William O. Lipinski (I) (D)

Did not respond.

11th Congressional District

Jerry Weller (R)

Should universal access to health care be immediate or phased in? Did not respond

System I support: Cooperation between government and the private sector

Position on employer mandates: Oppose

How the current system should be reformed: I advocate insurance reforms, use of medical savings accounts, standardization of insurance claim procedures and paperwork, an increase in the

federal retirement age from 55 to 62 and a phase-out of federal Medicare subsidies for senior citizens with incomes of more than \$100,000 a year.

Federal bills supported: The Affordable Health Care Now Act, sponsored by U.S. Rep. Bob Michel, because it attempts to increase access to health care, control costs and ease the health care burden on small businesses without

new government bureaucracy and taxes

Position on caps on noneconomic damages: Support a \$250,000 cap

Position on antitrust relief for physicians: Support

Suggestions for improving Illinois' health care system: Reform is needed at the federal level, but the states must take the lead and serve as laboratories for change. I introduced legislation in the

Illinois General Assembly that called for reducing regulatory burdens for cooperative purchasing of health insurance by small businesses and extending a 100-percent tax deduction to the self-employed and small employers who have between two and 50 employees. Tort reform and new tax breaks for physicians who provide charity care would also improve accessibility and reduce costs.

Frank Giglio (D)

Should universal access to health care be immediate or phased in? Phased in over the course of four to six years

(Continued on page 4)



BlueCross BlueShield of Illinois

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REPORT for Illinois Physicians

BOARD CERTIFICATION REQUIREMENTS

It is not uncommon for Blue Cross Blue Shield of Illinois (BCBSI) to receive inquiries from Illinois physicians regarding BCBSI's requirements that all contracted physicians in one of BCBSI's managed care products, namely Managed Care Network Preferred (MCNP), be American Board Certified. MCNP is a so-called "point-of-service" product, in which subscribers receive high levels of coverage when care is received from, or authorized by, a designated Primary Care Physician, but still have reduced levels of benefits when care is obtained "out of network", i.e., without authorization by the subscriber's Primary Care Physician. In addition, BCBSI is now requiring that all new physicians who participate in BCBSI's HMO Illinois network, be Board Certified, even though non-Board Certified physicians who already practice in one of HMOI's medical groups are being allowed to continue in the HMOI physician network, i.e., these non-Board Certified physicians are "grand-fathered" into the existing HMOI physician network. An additional exception is made by BCBSI for some specialists whose Board Certification process require a period of practice time between taking the first and the second parts of the certifying examination; in such situations, BCBSI will grant a provisional contract to the specialists who successfully completes the first part of the examination, with the understanding that the specialists must take and pass the second part of the examination at the earliest opportunity that is available to him

when, in order for him/her to receive a regular contract.

BCBSI has adopted this policy because almost universally BCBSI's customers demand that Board Certification should be part of the credentialing process for the network physicians who will provide care to those customers. BCBSI recognizes that many fine physicians, who provide high quality health care services, are not American Board Certified. However, Board Certification is objective evidence that a physician was able to demonstrate his/her competence in a certain specialty at least at the time the examination was passed. Consequently, the whole concept of specialty Board Certification is valid, and BCBSI believes that most American physicians agree with the Board Certification process. BCBSI intends to continue to engage in those processes that will demonstrate to BCBSI's customers that BCBSI is committed to promoting high quality health care services in a cost effective manner. Since Board Certification is so widely accepted, both within and outside of the medical profession, as a demonstration of having achieved a certain level of competence, BCBSI will continue to require Board Certification in the credentialing process of network physicians as described above.

Congressional candidates

(Continued from page 3)

System I support: Public-private partnership

Position on employer mandates: Oppose. I support mandates only if the reforms that will be implemented do not lead to adequate coverage. Buying pools and insurance reforms will lower costs and encourage people to purchase insurance. If we don't reach coverage targets by a certain time, such as the year 2000, employers and employees should be forced to split the cost of coverage.

How the current system should be reformed: Currently, the system discrim-

inates against middle-class families. Since people who can afford insurance buy it, and people who are poor are covered by the government, this is a middle-class problem. Even people who are covered wind up paying more due to cost shifting. Universal coverage is the only way to address these problems. Buying pools, portability, coverage for pre-existing conditions and uniform paperwork are all part of the solution.

Federal bills supported: The bill that comes closest to my position is the Mitchell bill because it leads to universal coverage. The change would not be radical under this bill, and there would be time to evaluate the progress of reform.

Position on caps on noneconomic damages: Oppose

Position on antitrust relief for physicians: Open to consideration of this reform, but need more information on the specifics

Suggestions for improving Illinois' health care system: Reform at the national level will address some of the problems we have here in Illinois. Obviously, we have a Medicaid problem. We are running at a deficit, and the delivery system is flawed. As our population ages, we will have a Medicare problem as well. National reform will give subsidies to these groups, allowing them to purchase private insurance instead of

trying to have the government insure them.

16th Congressional District

Donald Manzullo (I) (R)

Did not respond

Pete Sullivan (D)

Should universal access be immediate or phased in? Phased in

System I support: Public-private partnership

Position on employer mandates: Support

How the current system should be reformed: There should be universal coverage, coverage for working Americans regardless of previous conditions and cost containment by physicians and pharmaceutical and insurance companies.

Federal bills supported: None at this point. All the plans have merit and specific programs that should be initiated.

Position on caps on noneconomic damages: Oppose

Position on antitrust relief for physicians: Support, because it will help avoid the duplicative costs of maintaining health care facilities

Suggestions for improving Illinois' health care system: Did not respond

18th Congressional District

Ray LaHood (R)

Should universal access to health care be immediate or phased in? Phased in over four to five years

System I support: Public-private partnership

Position on employer mandates: Oppose. I support a mix of funding sources among employees, insurance companies, health providers, the government and employers.

How the current system should be reformed: Our goal should be to reform those functions of the health care system that need reforming while maintaining the efficient functions that currently work for the vast majority of Americans. Specifically, I support the Republican principles for reform that call for reduced cost through reliance on educated consumers, not government fiat; increased access through insurance reforms; choice for consumers about how and from whom they get their health care; flexibility for states and localities to design their own plans; fair tax treatment for all health care purchasers; individual responsibility for health care; and reform efforts based on proven successes, not bureaucratic designs.

Federal bills supported: The Affordable Health Care Now Act, sponsored by U.S. Rep. Bob Michel, because it is the fairest and most realistic plan

Position on caps on noneconomic damages: Support a \$250,000 cap

Position on antitrust relief for physicians: Support, because it will lead to more cooperation among hospitals, doctors and health professionals

Suggestions for improving Illinois' health care system: We must begin at the federal level and reform Medicaid at the state level.

G. Douglas Stephens (D)

Did not respond

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Clinical depression education campaign set

AWARENESS: Organizations focus on mental health. BY ANNA CHAPMAN

[CHICAGO] On Oct. 6, the Mental Health Association of Illinois will hold its fourth annual National Depression Screening Day in conjunction with National Mental Illness Awareness Week. Free health screenings will be held throughout Illinois and nationwide, according to the association. The event is part of the group's ongoing efforts to educate the public on clinical depression issues, said Rose Kurland, an Illinois coordinator for the National Public Edu-

cation Campaign on Clinical Depression. "This event has been highly successful in allowing people to learn about signs and symptoms of depression and whether follow-up treatment would be worthwhile," Kurland said. "The number of available sites in Illinois grew from 15 in 1992 to 74 in 1993."

For more than a year, the Illinois association has been working with the National Mental Health Association on the national public education campaign.

The campaign's goal is to reach 92 percent of American households, Kurland said. Campaign activities include local events to draw attention to the disease and newspaper, television and radio ads, which state that depression is a medical condition and that individuals should contact their physician if they have symptoms of depression.

In February, Illinois participants in the depression campaign presented a program linked with the Museum of Science

and Industry's "It's All in Your Head" exhibit. "Various presenters spoke on symptoms of depression, the economics of depression in the workplace and principles for creating effective and reasonable adaptations in the workplace," Kurland explained.

Currently, the campaign committee is designing a program targeting high school students, she said. "The plan is to involve area high school newspaper editors and reporters in a contest offering awards for excellence for articles concerning depressive illness."

A new speakers bureau will offer educational presentations to the business community, she added. ■

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Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

What goes around comes around

Lawyers are finally getting a taste of their own medicine. They're being sued for malpractice, the New York Times recently reported.

Evidence of this growing trend is the increase in legal malpractice insurance premiums, the story said, backing up its allegation with statistics. In 1970, lawyers paid less for their malpractice insurance than for car insurance. But annual premiums currently range from \$10,000 to \$15,000.

A partner in a Chicago law firm said this trend reflects the change in the lawyer-client relationship. Lawyers today are less likely to be out-of-court friends with their clients, and clients have fewer qualms about suing their lawyers. This change is about 15 years behind the same change in doctors' relationships with their patients, "just as the growth of legal malpractice claims has lagged behind the explosion of medical malpractice suits," noted the Chicago lawyer.

But are there grounds for these legal malpractice cases? Yes, according to a couple of attorneys who sue their fellow attorneys. There are "idiots" practicing law, explained one. Another switched from defending lawyers in legal malpractice cases to prosecuting them because of what he termed an epidemic of legal malpractice in this country. He said that during his career, he has encountered

malpractice cover-ups and lawyers trying to hide their mistakes from their clients.

The most common cause of a legal malpractice claim is loss of a case through sloppiness – preventable mistakes such as failing to file documents on time. A San Francisco lawyer who has written a book on legal malpractice said that the number of legal malpractice cases is increasing because of the glut of new lawyers and the resulting competition. These novices are more willing than their predecessors to take cases with little merit, he said.

For lawyers, malpractice suits are relatively new phenomena. For physicians, they've been a problem for years. A recent study conducted by the Illinois Department of Insurance showed that the number of medical malpractice claims skyrocketed between 1980 and 1992. In 1992, 3,494 claims were closed in Illinois, compared with only 620 in 1980. More than half of the medical malpractice claims closed in 1992 had no indemnity payments, but the average payment to defense counsel on those claims was \$10,705.

Although the trend of suing lawyers for malpractice has a down side – further clogging an already backlogged legal system – maybe it will help some attorneys change their minds about the need for tort reform.

PRESIDENT'S LETTER

A moment to decide

Alan M. Roman, MD



But on this misty and cool day, the warm glow inside was enough gratification for me.

It could just as easily have been Vermilion County's Howl at the Moon Run and Walk, the Decatur Autumn Shoreline Classic or the Starved Rock Canal Connection. Instead, slightly sore and somewhat spent, I approached the finish line of the Park Forest Scenic Ten, the annual Labor Day event that, for me, defines the passing of summer.

More than the cool, crisp nights or the increasingly later sunrises, this 10-mile hilly, winding course is indisputable proof that autumn has arrived. To me, it is the adult version of back to school.

Beginning with my surgical residency at the Mayo Clinic, running has metamorphosed into much more. This accomplishment is as remarkable for its genesis (as a whimsical dare) as for its testimonial to a physical fitness regimen that begins daily at 4:44 a.m. By taking responsibility for my health and that of my patients, I feel better about myself. I've always believed that to address the public's health concerns, we must first address ours.

For me, the annual run is a chance to measure my performance against the preceding year's and to renew my commitment to self, family and the profession. To physicians dedicated to professionalism and to the health of the public, that commitment requires an investment of time, effort and self.

We may give out or give in, but we should never give up. In time we learn to lead with our chins, and we get up – no matter how many times we are knocked down. The pessimist may be right, but the optimist has a better time on the trip. Those who say something is impossible shouldn't get in the way of those managing to get it done.

Autumn marks the start of a challenging period for physicians and organized medicine. Your Society is confronting such issues as the health system reform debate, managed care and malpractice reform. The political world changed rapidly this summer (while perhaps you weren't watching). Too much is going on. What we

thought yesterday will probably be obsolete tomorrow.

Certainly our members have come to expect change: It is inevitable. Perhaps what needs to be changed is our approach to change. Looking only to the past or present, we are sure to miss the future. But those who have confidence in themselves and their Society and who are willing to be innovative will stimulate a change in the events surrounding them. This summer, your Society's officers and leaders have redirected ourselves to increase ISMS' achievements and our members' satisfaction.

The challenges are upon us – and you – as never before. The level of your commitment will say as much about your Society's chances of success as about you and the way you will practice. You are free to the point of choice, then the choice will control you.

Your participation is critical, so that the Society's policies best represent the consensus of all its members. Many avoid participation, as if to say that by doing so, they won't have to make decisions. Other members are unwilling to invest of themselves. But if you don't invest, your outcome will be meaningless: Winning will be less sweet, and losing won't hurt as much. Rather than commit and lose, some will choose to lose without committing. I implore you to invest yourself in medicine's efforts to improve the quality of your life and your profession.

The finish line upon me, I blinked the sweat from my eyes to glance at the clock. No question about it – significantly faster than my time two years ago. A real cushion of contentment. I didn't win prize money or a trophy. That was reserved for the elite runners who came from far-off places with exotic names.

But on this misty and cool day, the warm glow inside was enough gratification for me. I again learned that uncommon commitment allows common people to achieve uncommon results. This year's Scenic Ten made a difference in my life and the trip along the way.

Quotables

"If I were Speaker Foley, I would put a fence around the House of Representatives and I wouldn't let any of them out, because once they get out, this bill is dead."

— **Oregon Sen. Robert Packwood**, ABC World News Tonight

"I think the charade, the political charade, will be if we push something through just for the sake of saying we pushed it through. That's politics and government at its worst."

— **New York Sen. Alfonse D'Amato**, New York Times

"I think the issues are a lot more complicated than are really being discussed."

— **Rick Flint, MD**, director of the emergency department at Reid Memorial Hospital in Richmond, Ind., Washington Post

"I hope there will be a cease-fire, a white flag raised and no more ad hominem attacks."

— **Maine Sen. William S. Cohen**, New York Times

"If we get 30 minutes, we talk about price controls. If we get 30 seconds, we talk about price controls."

— **Ray Egan**, senior vice president, Bristol-Myers, explaining the focus of the drug industry's lobbying, Wall Street Journal

"Data continues to show the drug companies are the most profitable industry in the United States. And data shows that they continue to spend more on marketing than on research and development."

— **John Coster**, assistant professor at the University of Minnesota's Prime Institute, Wall Street Journal

"I'm not afraid of managed care. I've been trained to practice in an environment of managed care

cost-effectiveness."

— **Adam Silverman, MD**, chief general internal medicine resident at Northwestern Memorial Hospital, Chicago Sun-Times

"We've got a delicate balancing act to pull off. We don't want to regulate managed care into oblivion, but on the other hand, we have to be sure that the interests of the patients and their health care providers are also protected."

— **New Jersey Health Commissioner Len Fishman**, addressing the contention surrounding proposed any-willing-provider legislation in his state, New York Times

"With science and treatment practices radically changing, it makes no sense for Congress to presume it knows best."

— New York Times editorial

"If you take away people's rights to hold doctors accountable for the bad things they do, then bad doctors will do more bad things and health care costs will go up, not down."

— **Roxanne Conlin**, of the Trial Lawyers of America, on the need for tort reform, ABC World News Tonight

"The amount of money expended by American businesses to defend against such [liability] cases is probably incalculable, but much of that effort is necessary because modern judges and juries refuse to reject such claims, even when they are unfounded in law or fact."

— **Michael A. Pope**, president of the International Association of Defense Counsel, Crain's Chicago Business

"The tobacco industry is telling American smokers that the anti-tobacco groups want a smoking prohibition. Those clever manipulative deceivers wish to paint a picture of the roaring '20s [in which] smokers would be pursued by G-men and Elliott Ness. This is a distortion. It's the 'big' lie."

— **AMA Trustee Randolph D. Smoak, MD**, This Week



"This is my personal injury attorney. Would there be any problem if he joined us in the delivery room?"

YOCON[®] YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

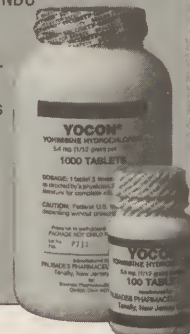
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

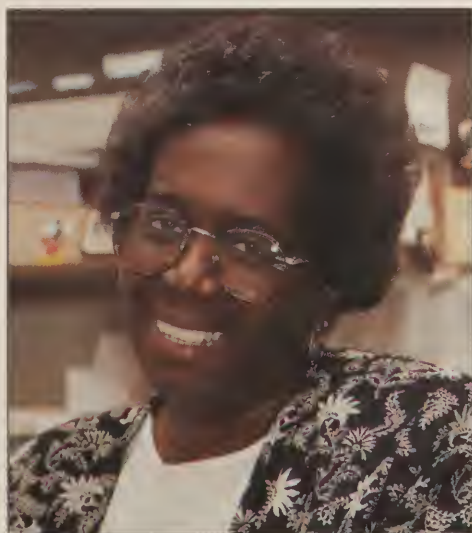
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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Carla Sommerfeld

AURELIA PERRY, ISMS membership coordinator, is the most recent recipient of the Society's bimonthly Employee Recognition Award. Perry was honored for the help she provided an ISMS member who transferred his membership from one Illinois county to another.

*HIV rulings
are a wake-up
call for
physicians*

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ISMIE Update

**Congressional
candidates'
positions on
tort reform**

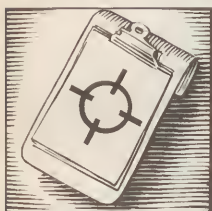
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Case in Point

Diligent follow-up protects physicians and patients

BY RICK PASZKIET

Besides being an integral part of high-quality patient care, consistent and diligent follow-up can help physicians avoid malpractice claims. But as the following cases demonstrate, haphazard follow-up can cause patients to fall through the cracks, resulting in lawsuits with judgments for the plaintiff.



Case #1

The case in brief: After a patient's Pap smear was found abnormal, she underwent a colposcopy. The physician, an Ob/Gyn, strongly advised her to return in six months for a follow-up Pap smear. The patient failed to have the repeat test and did not call for an appointment for a subsequent annual screening.

Three years after the initial abnormal Pap smear, she returned to the Ob/Gyn, complaining of pain during intercourse and pain in the lower left quadrant. The physician performed a Pap smear, which revealed that the patient had cervical cancer. Although the patient's cervix, uterus, fallopian tubes and ovaries were ultimately removed, she died of cervical cancer within a year. Her estate sued the physician, claiming that he failed to diagnose the decedent's cervical cancer.

At his deposition, the physician said he had explained to the patient the importance of the repeat Pap smear and therefore expected her to arrange for the follow-up test. The physician's records, however, contained no evidence of the conversation in which he discussed

the necessity of following up on her condition.

In addition, after the first six months, the Ob/Gyn made no further attempts to remind her of the need for the repeat test. Because of the physician's lack of evidence and inadequate follow-up, the case was settled in favor of the plaintiff.

Case #2

The case in brief: In May 1988, an internist discovered a thickening in the right breast of a patient he had been treating for nearly 15 years. Because the patient had a strong family history of breast cancer, the internist recommended a mammogram. The mammogram revealed one lesion, and the radiologist telephoned the internist with the results and followed up by sending copies of the radiographic findings to the internist's office.

The internist intended to inform the patient about her condition and the radiographic findings, but her chart was mistakenly refiled before he was able to write to the patient. A year later, she returned to the internist for an annual physical examination. The internist, now realizing that he had never followed up with the patient about the results of her 1988 mammogram, discovered a walnut-sized lump in her right breast. She was immediately referred to a surgeon, who performed a biopsy. The results showed a malignancy, and the patient underwent a radical mastectomy, followed by radiation and chemotherapy.

The patient subsequently sued the internist for failing to contact her with the results of the May 1988 mammogram and delaying the diagnosis and treatment of her breast cancer. The case was settled in favor of the plaintiff.

The points these cases make:

Both cases demonstrate that physicians bear the responsibility for ensuring adequate follow-up. The essential task for physicians is communicating information to the patient in a verifiable, documented manner, said Kevin Glenn, senior partner with Chicago's Bresler, Harvick and Glenn Ltd.

"The physician must bear in mind what and why he or she is trying to communicate to the patient," said Glenn. "When there is imminent danger to the patient, the physician's follow-up has to be extreme. The higher the danger, the greater the need for documentation."

According to Glenn, the Ob/Gyn in the first case should have sent the patient a certified letter about her condition and stapled the certified receipt in the patient's file for documentation. "In cases that involve life-threatening illnesses, the physician can't transfer responsibility to the patient. Follow-up, at least in the court's view, is frequently seen as the physician's concern."

If a patient's test results show any abnormality, the physician must be proactive in trying to inform the patient, said David Cromer, MD, an Evanston Ob/Gyn and a member of the ISMIE Risk Management Committee. "Some doctors keep a file of abnormal test results so that they can have immediate access to cases in which follow-ups need to be done," Dr. Cromer said. "Since physicians see a great volume of patients and typically have more than one office, they must establish a dependable follow-up system that works."

But how far must physicians go when it comes to follow-up procedures and documentation? "There is no requirement for the physician to have some hyper-technical system in place to track a patient's follow-up," said Glenn. "It's not necessary to have some elaborate computer software package to do your tracking. No matter what system you do use, it has to work, and, of course, the physician must follow that system."

The second case illustrates the

importance of training office staff about the proper filing of medical records, Dr. Cromer explained. "There are now risk management seminars available that teach office staff the correct procedures involved in patient follow-up. However, the ultimate responsibility for follow-up rests with the physician, who must make certain that tests are indeed performed and results communicated to the patient."

Dr. Cromer added that physicians must take the initiative for ensuring appropriate patient follow-up. "The first step is to establish a system that alerts the physician to any abnormal test results. Second, follow-up procedures have to be instituted so that files aren't put away by mistake. And, finally, everything has to be well-documented. Although such documentation can be time-consuming, it's a necessary safeguard for the physician."

"Case in Point" is a regular feature using hypothetical case histories to illustrate loss-prevention maxims.

MALPRACTICE ROUNDUP

Physician in HIV suit not subject to Federal Rehabilitation Act

A New York appeals court ruled recently that a physician who refused to treat an HIV-infected patient could be sued for malpractice but not for violation of the Federal Rehabilitation Act of 1973, according to a summary of *Doe vs. Jamaica Hospital*, published in the June 1994 issue of *Medical Malpractice Law & Strategy*.

The plaintiff voluntarily submitted to an HIV test when she registered in the hospital's high-risk prenatal unit, the summary said. After the physician and the hospital discovered that she was HIV-positive, they refused to treat her and recommended she have an abortion. The patient then sued the physician and the hospital for malpractice and violation of the Federal Rehabilitation Act.

An appeals court affirmed the lower court ruling that dismissed the plaintiff's claim related to the act but stated that her suit could proceed on the malpractice accusation. The appeals court said the physician was not subject to the provisions of the act, because he was a hospital employee and did not directly receive federal financial funding, according to the article. Congress limited the scope of the act to those who actually receive financial assistance, the case summary said.

No liability for failure to remove meconium

Placental abruption – not failure to intubate and remove meconium – resulted in a newborn's hypoxic brain damage, according to a New York court ruling in *McAteer by McAteer vs. Arden Hill Hospital*.

An infant who was born in a "severely depressed" state following the mother's placental abruption inhaled an undetermined amount of meconium moments after birth, according to an article in the *Malpractice Reporter*. The baby had trouble breathing and eventually experienced cardiac arrest, even after the Ob/Gyn cleared the baby's nose and mouth with a bulb syringe, used a catheter to suction meconium from her throat and administered oxygen. The court affirmed a jury verdict for the Ob/Gyn, the pediatrician and the hospital. All three defendants claimed the placental abruption had caused the brain damage prior to the baby's birth.

HIV treatment rulings are a wake-up call for physicians

LAWSUITS: Doctors cannot discriminate against AIDS patients.

BY MINDY KOLOF

[CHICAGO] Landmark decisions in two recent Illinois lawsuits make it illegal for health care providers to refuse treatment to HIV-infected patients solely on the basis of their disability, according to attorneys involved in the cases.

"Health care providers must learn that if they ignore the law, they will have to pay the price," said John Hammel, an attorney with the American Civil Liberties Union of Illinois.

The ruling in one of the cases, filed against an Arlington Heights physician, marked the first time in the United States that a doctor was ordered by a court to treat an HIV-positive patient, said James Schwartz, an attorney involved in the case.

According to the suit, the patient, Rodney Trovinger, sought treatment for chronic hepatitis B from William Mauer, DO. According to Trovinger's affidavit, he wanted to receive photoluminescence, a controversial "blood cleansing" therapy he heard was performed in the United States only by Dr. Mauer.

The affidavit states that Trovinger was refused treatment after he said he was HIV-positive. Dr. Mauer said his office staff and other patients would not approve of the doctor's treatment of someone with AIDS, according to the document.

Trovinger's suit was predicated on the 1992 Americans with Disabilities Act, which prohibits discrimination on the basis of a disability in places that do business with the public, according to one of Trovinger's attorneys, Susan Curry, executive director of the AIDS Legal Council of Chicago.

One day after the suit was filed, federal district Judge William Hart ordered Dr. Mauer to treat Trovinger within 48 hours, according to press reports. But on April 19, Trovinger died, five days after his first treatment, Curry said.

Dr. Mauer maintained that his refusal to treat Trovinger was based on concern for his other patients and staff as well as his belief that he didn't have the right to conduct the experimental procedure on an AIDS patient, according to his attorney, Ed Rothschild. But the court order gave him not only the right to perform the procedure but the obligation to do so, Rothschild said. "[Dr. Mauer] told Rodney he was worried about the complications of hepatitis B with HIV. His immune system was compromised, and he should be isolated to prevent infection. [Dr. Mauer] had no way to do that."

A similar action involving a Chicago dentist who refused to continue treatment because a long-time patient was HIV-positive was also resolved in the patient's favor. The dentist moved for dismissal of the complaint by arguing that he should have been allowed to refuse services to HIV-infected individuals because other dentists have done so and that he was unaware of how to provide dental care to those with HIV. However, the case was tried, according to an ACLU press release. The trial judge ruled that dentists' offices are places of public accommodation and that such facilities cannot discriminate on any basis protected under the Illinois Human Rights Act,

including disabilities, the ACLU said.

The rulings should serve as a warning to physicians to "tread carefully," said Saul Morse, ISMS vice president and general counsel. "The functional question is now, 'Why are you not providing treatment?' If you provide services to anyone in the community, as long as they meet

reasonable criteria, you can't discriminate against those with a disability, just as you can't refuse to treat women or blacks simply because they are women or blacks. Physicians will have to demonstrate that their actions are based on a genuine business or medical judgment, such as an inability to take on new patients."

Morse acknowledged the difficulty in dealing with patients who have contagious diseases but said using universal safety precautions manages the problem.

He cautioned that as the number of AIDS cases continues to increase, discrimination against such patients represents an emerging area of potential liability for physicians. "In other circum-

stances, you can lawfully terminate the physician-patient relationship as long as you follow the usual procedures. But if you're dealing with groups of people who have certain protection under the law, there's always the possibility they may say you refused treatment simply because they have AIDS."

To thwart possible litigation, Morse recommends that physicians take the following steps:

- Treat all prospective patients alike.
- Always use the universal precautions recommended for treatment.
- Ensure that any health-related reasons for denying care can be substantiated with sound medical evidence.

Seizures controlled, thoughts clear, smiles bright



Low risk of cognitive impairment¹

Generally avoids hirsutism^{2,3}

Avoids gingival hyperplasia^{2,3}



Tegretol 
carbamazepine USP

...because after seizure control, there's a lot of living to do!

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Tegretol is indicated as first-line monotherapy for children 6 years of age or older and adults. The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea, and vomiting. To minimize the possibility of such reactions, therapy should be initiated at the lowest possible dose. As with all anticonvulsant therapy, periodic hematologic evaluations are recommended at the physician's discretion. Although reports of transient or persistent decreased platelet or white blood cell counts are not uncommon in association with the use of Tegretol, the vast majority of cases of leukopenia have not progressed to the more serious conditions of aplastic anemia or agranulocytosis.

Please see complete Prescribing Information and references on next pages.

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Tegretol®

carbamazepine USP

Chewable Tablets of 100 mg - red-speckled, plnk

Tablets of 200 mg - pink

Suspension of 100 mg/5 ml

Prescribing Information

WARNING

APLASTIC ANEMIA AND AGRANULOCYTOSIS HAVE BEEN REPORTED IN ASSOCIATION WITH THE USE OF TEGRETOL. DATA FROM A POPULATION-BASED CASE CONTROL STUDY DEMONSTRATE THAT THE RISK OF DEVELOPING THESE REACTIONS IS 5-8 TIMES GREATER THAN IN THE GENERAL POPULATION. HOWEVER, THE OVERALL RISK OF THESE REACTIONS IN THE UNTREATED GENERAL POPULATION IS LOW, APPROXIMATELY SIX PATIENTS PER ONE MILLION POPULATION PER YEAR FOR AGRANULOCYTOSIS AND TWO PATIENTS PER ONE MILLION POPULATION PER YEAR FOR APLASTIC ANEMIA.

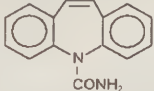
ALTHOUGH REPORTS OF TRANSIENT OR PERSISTENT DECREASED PLATELET OR WHITE BLOOD CELL COUNTS ARE NOT UNCOMMON IN ASSOCIATION WITH THE USE OF TEGRETOL, DATA ARE NOT AVAILABLE TO ESTIMATE ACCURATELY THEIR INCIDENCE OR OUTCOME. HOWEVER, THE VAST MAJORITY OF THE CASES OF LEUKOPENIA HAVE NOT PROGRESSED TO THE MORE SERIOUS COMITIONS OF APLASTIC ANEMIA OR AGRANULOCYTOSIS.

BECAUSE OF THE VERY LOW INCIDENCE OF AGRANULOCYTOSIS AND APLASTIC ANEMIA, THE VAST MAJORITY OF MINOR HEMATOLOGIC CHANGES OBSERVED IN MONITORING OF PATIENTS ON TEGRETOL ARE UNLIKELY TO SIGNAL THE OCCURRENCE OF EITHER ABNORMALITY. NONETHELESS, COMPLETE PRETREATMENT HEMATOLOGICAL TESTING SHOULD BE OBTAINED AS A BASELINE. IF A PATIENT IN THE COURSE OF TREATMENT EXHIBITS LOW OR DECREASED WHITE BLOOD CELL OR PLATELET COUNTS, THE PATIENT SHOULD BE MONITORED CLOSELY. DISCONTINUATION OF THE DRUG SHOULD BE CONSIDERED IF ANY EVIDENCE OF SIGNIFICANT BONE MARROW DEPRESSION DEVELOPS.

Before prescribing Tegretol, the physician should be thoroughly familiar with the details of this prescribing information, particularly regarding use with other drugs, especially those which accentuate toxicity potential.

DESCRIPTION

Tegretol, carbamazepine USP, is an anticonvulsant and specific analgesic for trigeminal neuralgia, available for oral administration as chewable tablets of 100 mg, tablets of 200 mg, and as a suspension of 100 mg/5 ml (teaspoon). Its chemical name is *5*H**-dibenz[b,f]azepine-5-carboxamide, and its structural formula is:



Carbamazepine USP is a white to off-white powder, practically insoluble in water and soluble in alcohol and in acetone. Its molecular weight is 236.27.

Inactive Ingredients: Tablets: Colloidal silicon dioxide, D & C Red No. 30 Aluminum Lake (chewable tablets only), FD&C Red No. 40 (200-mg tablets only), flavoring (chewable tablets only), gelatin, glycerin, magnesium stearate, sodium starch glycolate (chewable tablets only), starch, stearic acid, and sucrose (chewable tablets only). Suspension: Citric acid, FO&C Yellow No.6, flavoring, polymer, potassium sorbate, propylene glycol, purified water, sorbitol, sucrose, and xanthan gum.

CLINICAL PHARMACOLOGY

In controlled clinical trials, Tegretol has been shown to be effective in the treatment of psychomotor and grand mal seizures, as well as trigeminal neuralgia.

It has demonstrated anticonvulsant properties in rats and mice with electrically and chemically induced seizures. It appears to act by reducing polysynaptic responses and blocking the post-tetanic potentiation. Tegretol greatly reduces or abolishes pain induced by stimulation of the infraorbital nerve in cats and rats. It depresses thalamic potential and bulbar and polysynaptic reflexes, including the linguomandibular reflex in cats. Tegretol is chemically unrelated to other anticonvulsants or other drugs used to control the pain of trigeminal neuralgia. The mechanism of action remains unknown.

In clinical studies both suspension and conventional tablet delivered equivalent amounts of drug to the systemic circulation. However, the suspension was absorbed somewhat faster than the tablet. Following a b.i.d. dosage regimen, the suspension has higher peak levels and lower trough levels than those obtained from the tablet formulation for the same dosage regimen. On the other hand, following a t.i.d. dosage regimen, Tegretol suspension affords steady-state plasma levels comparable to Tegretol tablets given b.i.d. when administered at the same total mg daily dose. Tegretol chewable tablets may produce higher peak levels than the same dose given as regular tablets. Tegretol in blood is 76% bound to plasma proteins. Plasma levels of Tegretol are variable and may range from 0.5-25 µg/ml, with no apparent relationship to the daily intake of the drug. Usual adult therapeutic levels are between 4 and 12 µg/ml. Following chronic oral administration of suspension, plasma levels peak at approximately 1.5 hours compared to 4 to 5 hours after administration of oral tablets. The CSF/serum ratio is 0.22, similar to the 22% unbound Tegretol in serum. Because Tegretol may induce its own metabolism, the half-life is also variable. Initial half-life values range from 25-65 hours, with 12-17 hours on repeated doses. Tegretol is metabolized in the liver. After oral administration of ¹⁴C-carbamazepine, 72% of the administered radioactivity was found in the urine and 28% in the feces. This urinary radioactivity was composed largely of hydroxylated and conjugated metabolites, with only 3% of unchanged Tegretol. Transplacental passage of Tegretol is rapid (30 to 60 minutes), and the drug is accumulated in fetal tissues, with higher levels found in liver and kidney than in brain and lungs.

INDICATIONS AND USAGE

Epilepsy: Tegretol is indicated for use as an anticonvulsant drug. Evidence supporting efficacy of Tegretol as an anticonvulsant was derived from active drug-controlled studies that enrolled patients with the following seizure types:

- Partial seizures with complex symptomatology (psychomotor, temporal lobe). Patients with these seizures appear to show greater improvement than those with other types.
- Generalized tonic-clonic seizures (grand mal).
- Mixed seizure patterns which include the above, or other partial or generalized seizures.

Absence seizures (petit mal) do not appear to be controlled by Tegretol (see PRECAUTIONS, General).

Trigeminal Neuralgia: Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia.

Beneficial results have also been reported in glossopharyngeal neuralgia.

This drug is not a simple analgesic and should not be used for the relief of trivial aches or pains.

CONTRAINDICATIONS

Tegretol should not be used in patients with a history of previous bone marrow depression, hypersensitivity to the drug, or known sensitivity to any of the tricyclic compounds, such as amitriptyline, desipramine, imipramine, protriptyline, nortriptyline, etc. Likewise, on theoretical grounds its use with monoamine oxidase inhibitors is not recommended. Before administration of Tegretol, MAO inhibitors should be discontinued for a minimum of fourteen days, or longer if the clinical situation permits.

WARNINGS

Patients with a history of adverse hematologic reaction to any drug may be particularly at risk.

Severe dermatologic reactions including toxic epidermal necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome, have been reported with Tegretol. These reactions have been extremely rare. However, a few fatalities have been reported.

Tegretol has shown mild anticholinergic activity; therefore, patients with increased intraocular pressure should be closely observed during therapy.

Because of the relationship of the drug to other tricyclic compounds, the possibility of activation of a latent psychosis and, in elderly patients, of confusion or agitation should be borne in mind.

PRECAUTIONS

General: Before initiating therapy, a detailed history and physical examination should be made.

Tegretol should be used with caution in patients with a mixed seizure disorder that includes atypical absence seizures, since in these patients Tegretol has been associated with increased frequency of generalized convulsions (see INDICATIONS AND USAGE).

Therapy should be prescribed only after critical benefit-to-risk appraisal in patients with a history of cardiac, hepatic or renal damage, adverse hematologic reaction to other drugs, or interrupted courses of therapy with Tegretol.

Since a given dose of Tegretol suspension will produce higher peak levels than the same dose given as the tablet, it is recommended that patients given the suspension be started on lower doses and increased slowly to avoid unwanted side effects (see DOSAGE AND ADMINISTRATION).

Information for Patients: Patients should be made aware of the early toxic signs and symptoms of a potential hematologic problem, such as fever, sore throat, rash, ulcers in the mouth, easy bruising, petechial or purpuric hemorrhage, and should be advised to report to the physician immediately if any such signs or symptoms appear.

Since dizziness and drowsiness may occur, patients should be cautioned about the hazards of operating machinery or automobiles or engaging in other potentially dangerous tasks.

Laboratory Tests: Complete pretreatment blood counts, including platelets and possibly reticulocytes and serum iron, should be obtained as a baseline. If a patient in the course of treatment exhibits low or decreased white blood cell or platelet counts, the patient should be monitored closely. Discontinuation of the drug should be considered if any evidence of significant bone marrow depression develops.

Baseline and periodic evaluations of liver function, particularly in patients with a history of liver disease, must be performed during treatment with this drug since liver damage may occur. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.

Baseline and periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended since many phenothiazines and related drugs have been shown to cause eye changes.

Baseline and periodic complete urinalysis and BUN determinations are recommended for patients treated with this agent because of observed renal dysfunction.

Monitoring of blood levels (see CLINICAL PHARMACOLOGY) has increased the efficacy and safety of anticonvulsants. This monitoring may be particularly useful in cases of dramatic increase in seizure frequency and for verification of compliance. In addition, measurement of drug serum levels mayaid in determining the cause of toxicity when more than one medication is being used.

Thyroid function tests have been reported to show decreased values with Tegretol administered alone.

Hyponatremia has been reported in association with Tegretol use, either alone or in combination with other drugs.

Drug Interactions: The simultaneous administration of phenobarbital, phenytoin, or primidone, or a combination of two, produces a marked lowering of serum levels of Tegretol. The effect of valproic acid on Tegretol blood levels is not clearly established, although an increase in the ratio of active 10, 11-epoxide metabolite to parent compound is a consistent finding.

The half-lives of phenytoin, warfarin, doxycycline, and theophylline were significantly shortened when administered concurrently with Tegretol. Haloperidol and valproic acid serum levels may be reduced when these drugs are administered with Tegretol. The doses of these drugs may therefore have to be increased when Tegretol is added to the therapeutic regimen.

Concomitant administration of Tegretol with erythromycin, cimetidine, propoxyphene, terfenadine, isoniazid, flouxetine or calcium channel blockers has been reported to result in elevated plasma levels of total and/or free carbamazepine resulting in toxicity in some cases. Also, concomitant administration of carbamazepine and lithium may increase the risk of neurotoxic side effects.

Alterations of thyroid function have been reported in combination therapy with other anticonvulsant medications.

Breakthrough bleeding has been reported among patients receiving concomitant oral contraceptives and their reliability may be adversely affected.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carbamazepine, when administered to Sprague-Dawley rats for two years in the diet at doses of 25, 75, and 250 mg/kg/day, resulted in a dose-related increase in the incidence of hepatocellular tumors in females and of benign interstitial cell adenomas in the testes of males.

Carbamazepine must, therefore, be considered to be carcinogenic in Sprague-Dawley rats. Bacterial and mammalian mutagenicity studies using carbamazepine produced negative results. The significance of these findings relative to the use of carbamazepine in humans is, at present, unknown.

Pregnancy Category C: Tegretol has been shown to have adverse effects in reproduction studies in rats when given orally in dosages 10-25 times the maximum human daily dosage of 1200 mg. In rat teratology studies, 2 of 135 offspring showed kinked ribs at 250 mg/kg and 4 of 119 offspring at 650 mg/kg showed other anomalies (cleft palate, 1; talipes,1; anophthalmos, 2). In reproduction studies in rats, nursing offspring demonstrated a lack of weight gain and an unkempt appearance at a maternal dosage level of 200 mg/kg.

There are no adequate and well-controlled studies in pregnant women. Epidemiological data suggest that there may be an association between the use of carbamazepine during pregnancy and congenital malformations, including spina bifida. Tegretol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Retrospective case reviews suggest that, compared with monotherapy, there may be a higher prevalence of teratogenic effects associated with the use of anticonvulsants in combination therapy.

Therefore, monotherapy is recommended for pregnant women.

It is important to note that anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

Labor and Delivery: The effect of Tegretol on human labor and delivery is unknown.

Nursing Mothers: Ouring lactation, concentration of Tegretol in milk is approximately 60% of the maternal plasma concentration.

Because of the potential for serious adverse reactions in nursing infants from carbamazepine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children below the age of 6 years have not been established.

ADVERSE REACTIONS

If adverse reactions are of such severity that the drug must be discontinued, the physician must be aware that abrupt discontinuation of any anticonvulsant drug in a responsive epileptic patient may lead to seizures or even status epilepticus with its life-threatening hazards.

The most severe adverse reactions have been observed in the hemopoietic system (see boxed WARNING), the skin and the cardiovascular system.

The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea, and vomiting. To minimize the possibility of such reactions, therapy should be initiated at the low dosage recommended.

The following additional adverse reactions have been reported: **Hemopoietic System:** Aplastic anemia, agranulocytosis, pancytopenia, bone marrow depression, thrombocytopenia, leukopenia, leukocytosis, eosinophilia, acute intermittent porphyria.

Skin: Pruritic and erythematous rashes, urticaria, toxic epidermal necrolysis (Lyell's syndrome) (see WARNINGS), Stevens-Johnson syndrome (see WARNINGS), photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, erythema multiforme and nodosum, purpura, aggravation of disseminated lupus erythematosus, alopecia, and diaphoresis. In certain cases, discontinuation of therapy may be necessary. Isolated cases of hirsutism have been reported, but a causal relationship is not clear.

Cardiovascular System: Congestive heart failure, edema, aggravation of hypertension, hypotension, syncope and collapse, aggravation of coronary artery disease, arrhythmias and AV block, primary thrombophlebitis, recurrence of thrombophlebitis, and adenopathy or lymphadenopathy.

Some of these cardiovascular complications have resulted in fatalities. Myocardial infarction has been associated with other tricyclic compounds.

Liver: Abnormalities in liver function tests, cholestatic and hepatocellular jaundice, hepatitis.

Respiratory System: Pulmonary hypersensitivity characterized by fever, dyspnea, pneumonitis or pneumonia.

Genitourinary System: Urinary frequency, acute urinary retention, oliguria with elevated blood pressure, azotemia, renal failure, and impotence. Albuminuria, glycosuria, elevated BUN and microscopic deposits in the urine have also been reported.

Testicular atrophy occurred in rats receiving Tegretol orally from 4 to 52 weeks at dosage levels of 50 to 400 mg/kg/day. Additionally, rats receiving Tegretol in the diet for two years at dosage levels of 25, 75, and 250 mg/kg/day had a dose-related incidence of testicular atrophy and aspermatogenesis. In dogs, it produced a brownish discoloration, presumably a metabolite, in the urinary bladder at dosage levels of 50 mg/kg and higher. Relevance of these findings to humans is unknown. **Nervous System:** Dizziness, drowsiness, disturbances of coordination, confusion, headache, fatigue, blurred vision, visual hallucinations, transient diplopia, oculomotor disturbances, nystagmus, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, tinnitus, and hyperacusis.

There have been reports of associated paralysis and other symptoms of cerebral arterial insufficiency, but the exact relationship of these reactions to the drug has not been established.

Digestive System: Nausea, vomiting, gastric distress and abdominal pain, diarrhea, constipation, anorexia, and dryness of the mouth and pharynx, including glossitis and stomatitis.

Eyes: Scattered punctate cortical lens opacities, as well as conjunctivitis, have been reported. Although a direct causal relationship has not been established, many phenothiazines and related drugs have been shown to cause eye changes.

Musculoskeletal System: Aching joints and muscles, and leg cramps. **Metabolism:** Fever and chills. Inappropriate antidiuretic hormone (ADH) secretion syndrome has been reported. Cases of frank water intoxication, with decreased serum sodium (hyponatremia) and confusion, have been reported in association with Tegretol use (see PRECAUTIONS, Laboratory Tests).

Other: Isolated cases of a lupus erythematosus-like syndrome have been reported. There have been occasional reports of elevated levels of cholesterol, HDL cholesterol and triglycerides in patients taking anticonvulsants.

A case of aseptic meningitis, accompanied by myoclonus and peripheral eosinophilia, has been reported in a patient taking carbamazepine in combination with other medications. The patient was successfully dechallenged, and the meningitis reappeared upon rechallenge with carbamazepine.

DRUG ABUSE AND DEPENDENCE

No evidence of abuse potential has been associated with Tegretol, nor is there evidence of psychological or physical dependence in humans.

OVERDOSAGE

Acute Toxicity

Lowest known lethal dose: adults, >60 g (39-year-old man). Highest known doses survived: adults, 30 g (31-year-old woman); children, 10 g (6-year-old boy); small children, 5 g (3-year-old girl).

Oral LD₅₀ in animals (mg/kg): mice, 1100-3750; rats, 3850-4025; rabbits,1500-2680; guinea pigs, 920.

Signs and Symptoms

The first signs and symptoms appear after 1-3 hours. Neuromuscular disturbances are the most prominent. Cardiovascular disorders are generally milder, and severe cardiac complications occur only when very high doses (>60 g) have been ingested.

Respiration: Irregular breathing, respiratory depression.

Cardiovascular System: Tachycardia, hypotension or hypertension, shock, conduction disorders.

Nervous System and Muscles: Impairment of consciousness ranging in severity to deep coma. Convulsions, especially in small children. Motor restlessness, muscular twitching, tremor, athetoid movements, opisthotonos, ataxia, drowsiness, dizziness, mydriasis, nystagmus, adiadochokinesia, ballism, psychomotor disturbances, dysmetria. Initial hyperreflexia, followed by hyporeflexia.

Gastrointestinal Tract: Nausea, vomiting.

Kidneys and Bladder: Anuria or oliguria, urinary retention.

Laboratory Findings: Isolated instances of overdosage have included leukocytosis, reduced leukocyte count, glycosuria and acetonuria. EEG may show dysrhythmias.

Combined Poisoning: When alcohol, tricyclic antidepressants, barbiturates or hydantoina are taken at the same time, the signs and symptoms of acute poisoning with Tegretol may be aggravated or modified.

Treatment

The prognosis in cases of severe poisoning is critically dependent upon prompt elimination of the drug, which may be achieved by inducing vomiting, irrigating the stomach, and by taking appropriate steps to diminish absorption. If these measures cannot be implemented without risk on the spot, the patient should be transferred at once to a hospital, while ensuring that vital functions are safeguarded. There is no specific antidote.

Elimination of the Drug: Induction of vomiting.

Gastric lavage. Even when more than 4 hours have elapsed following ingestion of the drug, the stomach should be repeatedly irrigated, especially if the patient has also consumed alcohol.

Measures to Reduce Absorption: Activated charcoal, laxatives.

Measures to Accelerate Elimination: Forced diuresis.

Dialysis is indicated only in severe poisoning associated with renal failure. Replacement transfusion is indicated in severe poisoning in small children.

Respiratory Depression: Keep the airways free; resort, if necessary, to endotracheal intubation, artificial respiration, and administration of oxygen.

Hypotension, Shock: Keep the patient's legs raised and administer a plasma expander. If blood pressure fails to rise despite measures taken to increase plasma volume, use of vasoactive substances should be considered.

Convulsions: Diazepam or barbiturates.

Warning: Oiazepam or barbiturates may aggravate respiratory depression (especially in children), hypotension, and coma. However, barbiturates should not be used if drugs that inhibit monoamine oxidase have also been taken by the patient either in overdosage or in recent therapy (within one week).

Surveillance: Respiration, cardiac function (ECG monitoring), blood pressure, body temperature, pupillary reflexes, and kidney and bladder function should be monitored for several days.

Treatment of Blood Count Abnormalities: If evidence of significant bone marrow depression develops, the following recommendations are suggested: (1) stop the drug, (2) perform daily CBC, platelet and reticulocyte counts, (3) do a bone marrow aspiration and trephine biopsy immediately and repeat with sufficient frequency to monitor recovery.

Special periodic studies might be helpful as follows:

- white cell and platelet antibodies, (2) ⁵⁹Fe —ferrokinetic studies, (3) peripheral blood cell typing, (4) cytogenetic studies on marrow and peripheral blood, (5) bone marrow culture studies for colony-forming units, (6) hemoglobin electrophoresis for A₂ and F hemoglobin, and (7) serum folic acid and B₁₂ levels.

A fully developed aplastic anemia will require appropriate, intensive monitoring and therapy, for which specialized consultation should be sought.

DOSAGE AND ADMINISTRATION (see table below)

Monitoring of blood levels has increased the efficacy and safety of anticonvulsants (see PRECAUTIONS, Laboratory Tests). Oosage should be adjusted to the needs of the individual patient. A low initial daily dosage with a gradual increase is advised. As soon as adequate control is achieved, the dosage may be reduced very gradually to the minimum effective level. Medication should be taken with meals.

Since a given dose of Tegretol suspension will produce higher peak levels than the same dose given as the tablet, it is recommended to start with low doses (children 6-12 years: 1/2 teaspoon q.i.d.) and to increase slowly to avoid unwanted side effects.

Conversion of patients from oral Tegretol tablets to Tegretol suspension: Patients should be converted by administering the same number of mg per day in smaller, more frequent doses (i.e., b.i.d. tablets to t.i.d. suspension).

Epilepsy (see INOICATIONS AND USAGE)

Adults and children over 12 years of age — Initial: Either 200 mg b.i.d. for tablets or 1 teaspoon q.i.d. for suspension (400 mg per day). Increase at weekly intervals by adding up to 200 mg per day using a t.i.d. or q.i.d. regimen until the optimal response is obtained. Dosage generally should not exceed 1000 mg daily in children 12 to 15 years of age, and 1200 mg daily in patients above 15 years of age. Ooses up to 1600 mg daily have been used in adults in rare instances.

Maintenance: Adjust dosage to the minimum effective level, usually 800-1200 mg daily.

Children 6-12 years of age — Initial: Either 100 mg b.i.d. for tablets or 1/2 teaspoon q.i.d. for suspension (200 mg per day). Increase at weekly intervals by adding up to 100 mg per day using a t.i.d. or q.i.d. regimen until the optimal response is obtained. Oosage generally should not exceed 1000 mg daily.

Maintenance: Adjust dosage to the minimum effective level, usually 400-800 mg daily.

Combination Therapy: Tegretol may be used alone or with other anticonvulsants. When added to existing anticonvulsant therapy, the drug should be added gradually while the other anticonvulsants are maintained or gradually decreased, except phenytoin, which may have to be increased (see PRECAUTIONS, Drug Interactions and Pregnancy Category C).

Trigeminal Neuralgia (see INOICATIONS AND USAGE)

Initial: On the first day, either 100 mg b.i.d. for tablets or 1/2 teaspoon q.i.d. for suspension for a total daily dose of 200 mg. This daily dose may be increased by up to 200 mg a day using increments of 100 mg every 12 hours for tablets or 50 mg (1/2 teaspoon) q.i.d. for suspension, only as needed to achieve freedom from pain. Do not exceed 1200 mg/daily.

Maintenance: Control of pain can be maintained in most patients with 400 mg to 800 mg daily. However, some patients may be maintained on as little as 200 mg daily, while others may require as much as 1200 mg daily. At least once every 3 months throughout the treatment period, attempts should be made to reduce the dose to the minimum effective level or even to discontinue the drug.

HOW SUPPLIED

Chewable Tablets 100 mg—round, red-speckled, pink, single-scored (imprinted Tegretol on one side and 52 twice on the scored side)

Bottles of 100.....NOC 58887-052-30

Unit Oose (blister pack)

Box of 100 (strips of 10).....NOC 58887-052-32

Do not store above 86°F (30°C). *Protect from light and moisture.*

Dispense in tight, light-resistant container (USP).

Tablets 200 mg—capsule-shaped, pink, single-scored (imprinted Tegretol on one side and 27 twice on the partially scored side)

Bottles of 100.....NOC 58887-027-30

Bottles of 1000.....NOC 58887-027-40

Unit Dose (blister pack)

Box of 100 (strips of 10).....NOC 58887-027-32

Do not store above 86°F (30°C).

Protect from moisture. Dispense in tight container (USP).

Samples, when available, are identified by the word *SAMPLE* appearing on each tablet.

Suspension 100 mg/5 ml (teaspoon)—yellow-orange, citrus-vanilla flavored

Bottles of 450 ml.....NOC 58887-019-76

Shake well before using.

Do not store above 86°F (30°C).

Dispense in tight, light-resistant container (USP).

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C94-3 (Rev. 3/94)

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Ciba-Geigy Corporation
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Indication	Initial Oose		Subsequent Oose		Maximum Dose
	Tablet	Suspension	Tablet	Suspension	Tablet or Suspension
Epilepsy					
6-12 years of age	100 mg b.i.d. (200 mg/day)	1/ 2 teaspoon q.i.d. (200 mg/day)	Add up to 100 mg per day at weekly intervals, t.i.d. or q.i.d.	Add up to 1 teaspoon (100 mg) per day at weekly intervals, t.i.d. or q.i.d.	1000 mg/24 hours
Over 12 years of age	200 mg b.i.d. (400 mg/day)	1 teaspoon q.i.d. (400 mg/day)	Add up to 200 mg per day at weekly intervals, t.i.d. or q.i.d.	Add up to 2 teaspoons (200 mg) per day at weekly intervals, t.i.d. or q.i.d.	1000 mg/24 hours: 12-15 years 1200 mg/24 hours: over 15 years 1600 mg/24 hours: adults, in rare instances
Trigeminal Neuralgia	100 mg b.i.d. on the first day (200 mg/day)	1/ 2 teaspoon q.i.d. (200 mg/day)	Add up to 200 mg per day in increments of 100 mg every 12 hours	Add up to 2 teaspoons (200 mg) per day q.i.d.	1200 mg/24 hours

New cancer approval program created

MANAGED CARE: HMOs and PPOs can seek assessments of the care they provide to cancer patients. BY KAREN SANDRICK

[CHICAGO] Recognizing the dramatic growth of managed care in the United States, the Commission on Cancer of the American College of Surgeons has established a new organizational category for managed care groups in its nationwide voluntary approval program. By including managed care plans in the approval program, the commission hopes to provide a benchmark against which HMOs, PPOs and other entities can assess their treatment of cancer patients, according to the commission.

"Managed care organizations that receive approval by the Commission on Cancer may rest assured that they are meeting specific standards regarding the comprehensive delivery of cancer care, that they are measuring outcomes of their care and that they are providing lifelong follow-up of patients wherever the patients go for treatment within the network of managed care participants," said Gena Opaluch, administrative manager of the commission's approval section.

To ensure that cancer programs offer the best in diagnosis and treatment, the commission's overall approval program has assessed the management of cancer patients since 1932, according to program materials. The program's objective is reducing patient morbidity and mortality by encouraging cancer treatment facilities to improve prevention, early detection, pretreatment evaluation, staging, therapy, rehabilitation, follow-up surveillance and care of the terminally ill, the commission said.

"We want to be sure patients have the benefit of a thoughtful audit of patient care at the institutions at which they are cared for," said David P. Winchester, MD, medical director of the American College of Surgeons' cancer department and director of surgery at Evanston Hospital. "We want to be sure they have a committee of dedicated professionals from various disciplines who consider how the institution is treating the various cancers it sees."

FHP Inc. of Cerritos, Calif., is the first managed care organization to obtain approval from the commission for its cancer care, officials said. The organization coordinates a managed care cancer program for individuals in Long Beach and Orange County in California and worked with the commission to develop the new category for managed care organizations, according to commission materials.

Other managed care organizations may not be able to obtain approval for a few years because they must demonstrate a history of comprehensive, multidisciplinary cancer care, the commission said. Those organizations will be subjected to the same approval process as hospital-based and freestanding cancer centers.

THE COMMISSION will not use formal practice guidelines to judge the clinical activities of physicians in managed care programs. "The approvals program hasn't entered the practice of medicine to that degree," Dr. Winchester said. However, he noted that "overall practice guidelines, particularly for the diagnosis and evaluation of patients suspected of having cancer, will be important as the

health care system changes."

He cited existing guidelines for primary care physicians who may have first contact with cancer patients. Those guidelines were created by the Commission on Cancer and the U.S. Centers for Disease Control and Prevention and address the evaluation of breast abnormalities. The CDC will distribute the guidelines to state health departments soon, he said.

The commission's approval program prefers to encourage cancer programs to manage treatment issues on their own, Dr. Winchester said. The program generates a substantial amount of data about patients through a nationwide tumor registry and feeds the information back to individual facilities "as a beacon or a barometer of the kind of care the facilities are rendering," he explained.

The commission expects individual cancer programs to take whatever actions are necessary to resolve significant problems, Dr. Winchester said. "If a cancer program is seeing large numbers of patients with advanced cases of cancer, it needs to examine the practice of its primary care physicians to see if they are doing the right things to pick up cancers earlier, such as identifying patients at high risk and subjecting them to specific screening tests."

"Our role in approvals is to assure that the elements for quality care are in place in all the types of facilities and organizations that provide care to cancer patients," he said. ■



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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



Bristol-Myers Squibb Company

Physicians’ role

(Continued from page 1)

Although S.B. 398 does not prevent hospitals from using economic criteria unrelated to quality of care in determining hospital staff appointments, it does contain important due process provisions to protect the medical staff privileges of individual physicians based on the delivery of quality care, said Saul Morse, ISMS vice president and general counsel.

For physicians to receive the full benefits of the due process protections in the legislation, their hospital medical staff bylaws must incorporate the substance of the measure’s provisions, Dr. Welch added.

The most significant benefit of the legislation is a provision enabling physicians to dispute any adverse decisions before a “mutually agreeable panel of the hospital and medical staff,” Morse said. The hearings will allow physicians to openly argue their case and will give physicians and hospitals greater insight into the practice of economic credentialing and its effect on the quality of care and access, he said. In addition, hospital governing boards will be required to provide physicians with a written explanation of why medical staff privileges and membership have been terminated or limited, he noted.

“This new law will bring into the open

how important economic criteria are and what specific criteria are used in determining medical staff privileges,” Morse said. “It also will give [physicians] a sense of how prevalent the practice of economic credentialing is and whether or not economic criteria are more important to hospitals than quality of care issues.”

To address physicians’ fears that economic credentialing will leave patients without access to quality health care, the legislation also provides physicians with 15 days’ notice before their staff privileges are terminated, Morse said. That provision allows time for physicians and their patients to make alternate arrange-

ments for care, he added.

According to Morse, the due process provisions will also apply to physicians who lose their privileges because of a hospital’s decision to award an exclusive contract. Displaced physicians will receive a fair hearing to argue their case and at least 15 days’ notice before their privileges are terminated, he said.

In preparation for the legislation’s Jan. 1 implementation, ISMS’ Lawyer Referral Network can help physicians find the legal resources they need to ensure that their hospital medical staff bylaws include the legal protections in the legislation, Dr. Welch said. Through the network, ISMS members can obtain a referral to an attorney who participates in the network and is knowledgeable about legal issues affecting doctors, including economic credentialing, he added. Physicians may access the network by calling the ISMS action line at (800) MD-ASIST.

“It is necessary for physicians to understand the new law when they sign [hospital] contracts or whenever issues of economic credentialing come up, because this legislation will weigh greatly on their ability to practice medicine,” Morse said.

IHA seminar

(Continued from page 1)

individual’s qualifications for initial or continuing medical staff privileges,” he said. The measure refers to inappropriate uses rather than all uses of economic criteria in the credentialing process, he added.

Because the legislation stipulates that hospital medical staff bylaws must include rules for “granting, limiting, renewing or denying medical staff membership and clinical staff privileges” that are consistent with the measure’s provisions, many Illinois hospitals will need to negotiate bylaws changes with their medical staffs, Callahan said. “Bylaws aren’t changed that easily. But the last entity you want to interpret your bylaws is a court of law. Don’t leave that to chance. You decide these issues.”

Minimum procedures for initial applicants should be listed in the bylaws but should not include numerous rules and regulations, according to Callahan. Bylaws should be streamlined as much as possible, he added. Under the legislation, medical staffs must inform each applicant of the reasons for any adverse decision, Callahan said. “This is good. It forces you to be held to a standard and will protect you in the long run. It’s also fair to the physician.”

Most existing bylaws already substantially comply with the legislation’s minimum procedures for current staff members, Callahan continued. These procedures require hospital governing boards to provide written notice of an adverse decision and include all reasons for the decision. In addition, the hospital must inform physicians of their right to request a hearing before a panel agreed upon by the hospital and the medical staff. Before implementation of an adverse decision based substantially on economic factors, 15 days’ notice must have been given and the physician must have exhausted all applicable procedures in the legislation and the medical staff bylaws, according to the bill.

“Both hospitals and physicians find themselves in a time of change,” Nodzenski concluded.

PRAVACHOL®

Pravastatin Sodium Tablets

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of child-bearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST, and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper normal limit, was rare (< 0.1%) in pravastatin clinical trials. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis (e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy).

The risk of myopathy during treatment with another HMG-CoA reductase inhibitor is increased with concurrent therapy with either erythromycin, cyclosporine, niacin, or fibrates. However, neither myopathy nor significant increases in CPK levels have been observed in three reports involving a total of 100 post-transplant patients (24 renal and 76 cardiac) treated for up to two years concurrently with pravastatin 10-40 mg and cyclosporine. Some of these patients also received other concomitant immunosuppressive therapies. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. Further, in clinical trials involving small numbers of patients who were treated concurrently with pravastatin and niacin, there were no reports of myopathy. Also, myopathy was not reported in a trial of combination pravastatin (40 mg/day) and gemfibrozil (1200 mg/day), although 4 of 75 patients on the combination showed marked CPK elevations versus one of 73 patients receiving placebo. There was a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy (see PRECAUTIONS: Drug Interactions). The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination.

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3-oxohydroxy isomeric metabolite (S0 31,906). A small increase was seen in mean AUC values and half-life (t_{1/2}) for the inactive enzymatic hydroxylation metabolite (S0 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin: See WARNINGS: Skeletal Muscle.

Antipyrine: Since concomitant administration of pravastatin had no effect on the clearance of antipyrine, interactions with other drugs metabolized via the same hepatic cytochrome isozymes are not expected.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and C_{max} of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC_{0-12h} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites S0 31,906 and S0 31,945 was not altered.

Cyclosporine: Some investigators have measured cyclosporine levels in patients on pravastatin, and to date, these results indicate no clinically meaningful elevations in cyclosporine levels. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, C_{max}, and T_{max} for the pravastatin metabolite S0 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with aspirin, antacids (1 hour prior to PRAVACHOL (pravastatin sodium), cimetidine, nicotinic acid, or probucol, no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to; diuretics, anti-hypertensives, digitals, ACE inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p < 0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥ 50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallenian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallenian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg/day dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p < 0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p < 0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/– mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear. **Pregnancy: Pregnancy Category X:** See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (Vater association) in a baby born to a woman who took another HMG-CoA reductase inhibitor with dextroamphetamine sulfate during the first trimester of pregnancy. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time.

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

Body System/Event	All Events %		Events Attributed to Study Drug %	
	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

* Statistically significantly different from placebo.

The following effects have been reported with drugs in this class; not all the effects listed below have necessarily been associated with pravastatin therapy.

Skeletal: myopathy, rhabdomyolysis, arthralgia.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy, anxiety, insomnia, depression.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, dermatomyositis, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, eosinophilia, arthritis, arthralgia, urticaria, Stevens-Johnson syndrome, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including erythema multiforme.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecostasia, loss of libido, erectile dysfunction.

Skin: alopecia, pruritus. A variety of skin changes (e.g., nodules, discoloration, dryness of skin/mucous membranes, changes to hair/nails) have been reported.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Abnormalities: elevated transaminases, alkaline phosphatase, and bilirubin; thyroid function abnormalities.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy.

Anemia, thrombocytopenia, and leukopenia have been reported with HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: Skeletal Muscle and PRECAUTIONS: Drug Interactions.)

OVERDOSAGE

To date, there are two reported cases of overdosage with pravastatin, both of which were asymptomatic and not associated with clinical laboratory abnormalities. If an overdose occurs, it should be treated symptomatically and supportive measures should be instituted as required.

Consult package insert before prescribing PRAVACHOL (pravastatin sodium).

(Revised 1-94)

(J4-422E)



GATEKEEPERS

Guiding patients through managed care plans

UR, specialist referrals and patient education are just a few of the issues primary care physicians are handling successfully.

BY KATHY L. WILKEY

Gatekeepers have a big job. For starters, they're responsible for performing utilization review, maintaining quality assurance and introducing patients to the system.

As gatekeepers, primary care physicians are charged with "directing and guiding care on a cost-effective basis," said Richard Ingram, president of Chicago-based Integrated Health Care Solutions. To do so, they need to understand the costs of care. They can uncover potentially inappropriate treatment patterns by using data provided by the managed care plan or an outside data management firm and comparing specialists' charges based on the same diagnosis, he noted. "If you have 10 doctors in the same field and one's [charges] are substantially higher than the others', you look at the demographics of patients and their severity of illness and make those adjustments. Then, you can indicate to this doctor that there might be a better way to do this."

That kind of feedback can change physician behavior, said James Unland, president of the Health Capital Group, a Chicago health care management consulting firm. "It allows them to self-regulate. When physicians see that colleagues are performing differently, they change their behavior." If the physician doesn't conform, the gatekeeper can stop referring to that specialist.

Physicians and patients are concerned that such conformance to utilization review criteria may jeopardize quality of care. But consultants agreed that quality assurance is as integral to managed care as cost containment and that it has become the responsibility of the gatekeeper.

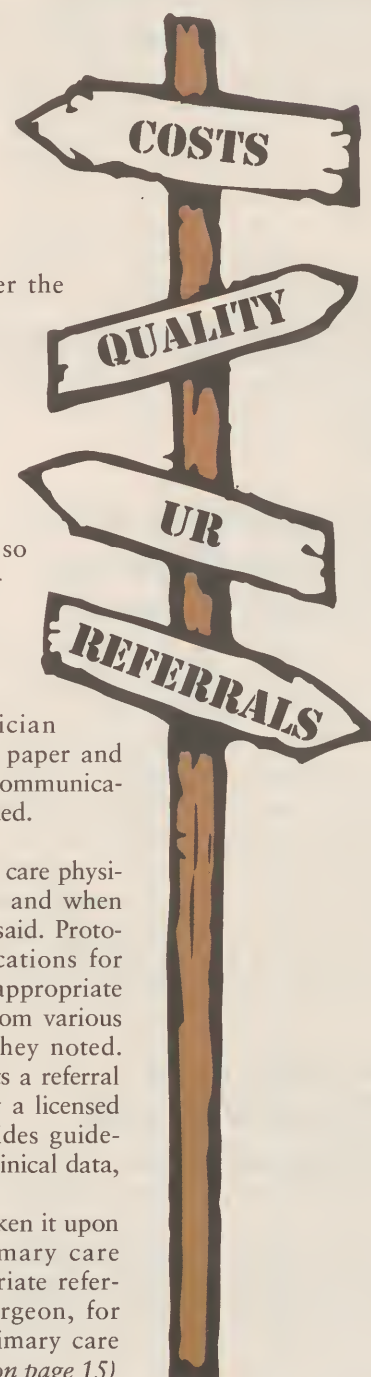
"One problem [with fee for service] has been that when a primary care physician refers to a specialist,

that specialist takes over the patient entirely," said Ingram. Under the gatekeeper model, that specialist must report back to the primary care physician on the course of the treatment provided, the patient's response and any follow-up care, so that the primary care doctor can continuously monitor quality and costs, he said. Although this has created a large paper trail, some physician offices have reduced the paper and phone work by on-line communication via computers, he added.

TO ENSURE QUALITY, primary care physicians should know when and when not to refer, consultants said. Protocols specifying the indications for referrals, as well as the appropriate specialist, are available from various medical organizations, they noted. Ingram's firm offers clients a referral hot line that is staffed by a licensed physician and that provides guidelines based on the latest clinical data, he said.

Some specialists have taken it upon themselves to help primary care physicians make appropriate referrals. "An orthopedic surgeon, for instance, may let the primary care

(Continued on page 15)



New responsibilities carry risk

BY KATHY L. WILKEY

As the responsibilities of primary care physicians increase in the gatekeeper model, so does their exposure to liability. But lawyers say primary care physicians can take measures to reduce their risks.

The increased liability arises from several sources, including the "pressure to staunch the flow through the gate [in response to] business pressure as opposed to medical pressure, and second-guessing

specialists or the need for specialized care," said Thomas Conley, an attorney with the Chicago law firm of Burditt & Radzius and a participant in ISMS' Lawyer Referral Network.



Even though the gatekeeper feels pressure to make decisions on a cost-effective basis, a "physician still has to exercise good medical judgment," said Anne M. Murphy, an attorney with Chicago's Vedder, Price, Kaufman & Kammholz. "One of the most common issues that crops up in the managed care environment, for all providers, is what do you do, or what can you do, if your medical judgment doesn't correspond with [that of] the plan?" Appeal, advised Murphy,

also a participant in the Lawyer Referral Network.

"It's extremely important that the physician follow through with the internal appeals process," she said. If the patient later files suit against the physician, the performance of physician duties will be questioned and a jury may view an appeal to be part of ensuring access to sound medical care, she noted.

"The physician should keep good documentation of those events," said Murphy. This includes taking down the name of the plan administrator with whom he or she spoke, the date and time of conversation and copies of any written communication with the plan regarding the case.

Primary care physicians also perform a utilization review function, determining the need for specialized care. As long as the physician uses sound medical judgment and documents decisions, the documentation will show that the actions were taken with the patient's best interests in mind, not the plan's or the doctor's bottom line, Conley added.

Trial lawyers and juries can misconstrue the motives of physicians whose compensation is affected by the number of patients they treat or their ability to contain costs. "I think that even though a gatekeeper may be doing a good job, that potential [financial] bias will not go over well with a jury," Conley said. That makes it especially important for physicians to exercise sound clinical judgment.

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Physicians will have to police themselves more carefully to make sure that the groups they are in have a good quality assurance program.

ment, document and appeal any differences with the plan, according to risk management specialists.

While gatekeepers may be encouraged to refer patients to network specialists, that shouldn't add risk, Conley said. "It's the same sort of situation that has always existed in hospitals where they have a closed staff. Only if the physician becomes privy to information regarding the [specialist's] quality of care and fails to act upon that information would there be any sort of implications there. [Physicians] will have to police themselves more carefully to make sure that the groups they are in have a good quality assurance program."

ISMS members seeking an attorney to counsel them on legal issues related to managed care may obtain a referral through the Society's Lawyer Referral Network. To access the network, call (800) MD-ASIST.

In addition, the ISMIE Risk Management Committee will conduct a seminar on liability issues stemming from managed care on Nov. 16 in Chicago and Nov. 17 in Collinsville. For more information, call the risk management department at (312) 782-1654 or (800) 782-ISMS.

OPEN ENROLLMENT ENDS 10-31-94

Gatekeepers

(Continued from page 13)

physician know that he should not have referred that shoulder-injury patient to him but there were things the primary care physician should have done to treat the patient," said Sandra Gill, president of Physician Management Resources Inc., based in Westmont. If specialists haven't begun such discussions with primary care physicians, gatekeepers might take the first step, Unland suggested.

Consultants agreed that if quality of care is at issue, primary care physicians should explore the possibility of out-of-network referrals. Most managed care plans allow for them, they said. However, because the plan may reimburse at a lower rate for out-of-network referrals, physicians should explain to patients that they may face a higher co-payment.

The strictest HMOs still prohibit out-of-network referrals except in emergencies or because of unusual geographical barriers to network providers, said Anne M. Murphy, an attorney with Chicago's Vedder, Price, Kaufman & Kammholz and a participant in ISMS' Lawyer Referral Network. Before contracting with such a plan, physicians should determine their confidence in the other physicians and hospitals affiliated with the plan, she said. Primary care physicians should ask the plan for information on the credentials of its participating specialists, Ingram said. To help familiarize gatekeepers with available specialists, plans or consultants representing plans may provide information about participating specialists, such as their education, published articles and languages spoken, he added.

Patient education is the key to success with the gatekeeper model, the consultants agreed. Although the plan is responsible for informing patients about the system and patient responsibilities, the amount of information varies from plan to plan.

A family physician who has participated in HMOs for several years said he has found that many patients believe primary care physicians interfere with their ability to receive the care they want. It's important to communicate that "you aren't trying to restrict their access to care, but [that you are trying] to help them get to the proper place," said John Finn, MD, who practices near New Orleans.

"The whole idea of these [plans] is to bring the patient back through us, the primary care physician, and let us generate referrals as necessary. In many cases, what the patient thinks he needs is not what he needs at all. And often he goes to the wrong specialist [for his problem]," Dr. Finn continued.

In their role as gatekeepers, primary care physicians can help improve the quality of patient care, Dr. Finn said. "When we first got involved with one of the HMOs down here, they were averaging 30 patient visits a day to the emergency room. By simply telling the patients, 'If you go to the emergency room without getting approval from your primary care physician, you have to pay for it, but if you get your primary care physician's OK, you don't have to pay for it,' we trained people to call us first. Within six months, we had that figure down to 1.3 visits per day [at a cost of] \$367 per visit. That's a significant savings. And is the medical care just as good? I think it's a lot better." ■

MEMBERS IN THE NEWS

Northwestern Memorial Hospital in Chicago recently announced the election of a new slate of officers for the hospital medical staff. The new chief of staff is Robert Vanecko, MD, a thoracic surgeon with special interests in adult cardiothoracic and lung cancer surgery. A graduate of Northwestern University School of Medicine, he succeeds internist John Marquardt, MD, who will assume the post of immediate-past chief of staff. Dr. Vanecko was also elected to the Northwestern Memorial Hospital Board of Directors.

Cardiologist Andrea Baumgartner, MD, who has served

as the medical staff's secretary/treasurer for the past two years, was elected vice chief of staff. She is a graduate of Loyola University's Stritch School of Medicine. Dr. Baumgartner will also serve on the Northwestern Memorial Corp. Board of Directors.

Northwestern's new medical staff secretary/treasurer is Melvyn Bayly Jr., MD, a Northwestern University medical school graduate. An Ob/Gyn, Dr. Bayly's special interests are colposcopy, laser surgery of the lower genital tract and abnormal Pap smears. ■

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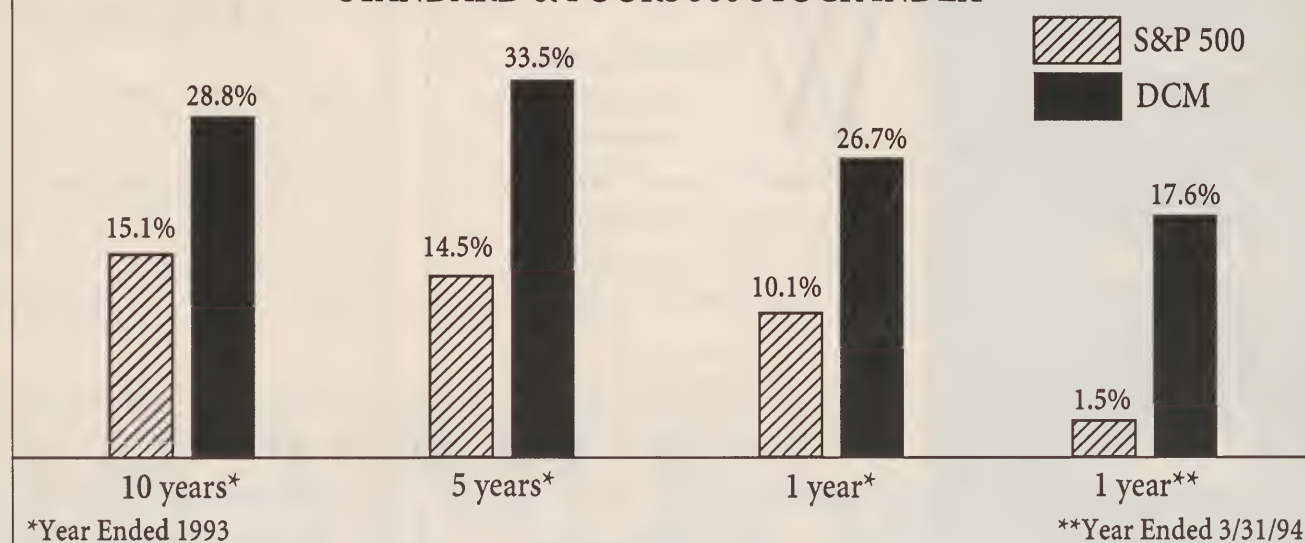
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State vaccines*(Continued from page 1)*

tions are also eligible to receive free vaccinations, but they must receive the shots at federally qualified health centers or rural health clinics, he noted.

Although the federal program is limited to eligible children, individual states may opt to expand the program to cover all children, Galati said. Illinois is currently planning to use state funds for a supplemental program that will provide the immunizations in physicians' offices to all children, he explained. The expansion corresponds with ISMS policy, which calls for the Society to work with IDPH to provide immunization materials at no cost to all practicing physicians who provide health care to children.

"We certainly support this program or any program trying to provide immunizations for 90 to 100 percent of Illinois children," said Crystal Cash, MD, who has represented IAFP at meetings to discuss program implementation. "Our concerns are based on keeping children with their primary care physicians."

Dr. Cash noted that physician-patient relationships may be interrupted when doctors send underinsured children to federally qualified health centers or rural health clinics to receive free immunizations, as required by the federal program.

"By participating in the Vaccines for Children program, physicians can demonstrate commitment to immunizing children at the appropriate ages," said

Mark Rosenberg, MD, chairman of the governmental affairs committee of the Illinois chapter of AAP.

Private practice physicians who participate in the program can save their patients as much as \$270 by providing the free vaccines, according to a fact sheet from the U.S. Centers for Disease Control and Prevention. Although they may not charge for the vaccine itself, physicians may charge for the office visit and bill an administration fee to be set by the U.S. Department of Health and Human Services. However, physicians may not deny vaccines to eligible patients who cannot pay the administration fee.

Participating physicians must screen the parents and guardians of children seeking vaccinations to determine patients' eligibility, Galati said. Physicians will be asked to keep records of those screenings. Doctors must also provide patients with materials on the risks and benefits of the various vaccines and document in the medical record the vaccine manufacturer and lot number, the date of immunization and the name and address of the administering provider, Galati added.

To enroll in the vaccine program, Illinois physicians must complete the forms they will soon receive from IDPH and return them to the department.

Although IDPH is planning to proceed with physician enrollment so that operation can begin on Oct. 1, implementation problems at the federal level could postpone the program for a month or two, he noted. ■

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Member briefing

(Continued from page 1)

high-quality patient care, he noted.

Such a plan must include antitrust reform, Dr. Brown said. The Health Care Quality Improvements Act of 1993, introduced as S. 1658 and H.R. 3486 by U.S. Sen. Orrin Hatch (R-Utah) and U.S. Rep. Bill Archer (R-Texas), would provide "modest" antitrust relief for physicians, he explained.

The legislation calls for the creation of safe harbors for a variety of cooperative activities undertaken by physicians, Dr. Brown said. "By combining resources, health care costs would be reduced while giving physicians the ability to provide better patient care."

ISMS ALSO BELIEVES tort reform is a critical component of health system reform, Dr. Kobler said. Specifically, the Society supports a \$250,000 cap on noneconomic damages in all malpractice suits, he noted.

"Physicians have been fighting for meaningful lawsuit reform for well over a decade," Dr. Kobler said. "With the debate over health care reform, this fight has taken on added urgency."

ISMS also supports inclusion of the Patient Protection Act in any federal reform plan that ultimately passes Congress, Dr. Brown said. Introduced as S. 2196 and H.R. 4527, the legislation was developed by the AMA and drafted by a bipartisan group. The bills aim to protect patients from the indifferent, bottom-line medical care offered by some large managed care conglomerates.

"All three of these elements – antitrust relief, tort reform and the Patient Protection Act – should be part of any health care system reform plan," Dr. Brown

House of Representatives, he noted.

Supporters of the bill calling for the \$250,000 cap are expected to reintroduce it after the fall elections, Dr. Kobler said. He added that physicians should



Dr. Kobler

focus on creating a "medical majority" in the Illinois House by supporting pro-medicine candidates campaigning in local elections.

Statewide races also have implications for

physicians. For example, in the race for attorney general, the Democratic candidate Al Hofeld is "one of the most notorious malpractice plaintiff's attorneys around," Dr. Kobler said. In contrast, Republican Jim Ryan has been willing to listen to the physician perspective on tort reform, he noted.

Physicians should also look closely at the differences in positions of the gubernatorial candidates – Jim Edgar, the one-term Republican incumbent, and Democrat Dawn Clark Netsch, Illinois' comptroller, Dr. Kobler said. "What good will a medical majority in the General Assembly do if we do not have a friend of medicine in the governor's

mansion, especially on the issue of tort reform?"

Physicians at the Will-Grundy meeting liked what they heard. "I've heard and read ongoing comments on [reform] on television and in newspapers for many months now," said Gerard Cerniak, MD. "I was here to get educated to the ISMS point of view and to be directed as far as what actions we might take to support those measures that would seem to benefit medicine the most."

Will-Grundy Medical Society President Holly Gunderson, MD, said she appreciated the clear-cut information provided. She called the meeting "enlightening regarding activities in Washington." ■

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The ASH designated this continuing medical education activity for 14 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

*Physicians have been
fighting for meaningful
lawsuit reform for well
over a decade.*

said. "If we are to achieve this goal in Washington, we'll need your help in contacting your U.S. representatives and senators about health care reform."

Dr. Brown encouraged attendees to write to their legislators and include personal experiences with health care delivery and physician and patient needs related to reform, he said. Physicians might also ask their patients to write letters, Dr. Brown suggested.

Reiterating the importance of contact with legislators, Theodore Kanellakes, MD, a member of the Will-Grundy Medical Society board, shared the results of meetings with U.S. Rep. George Sangmeister (D-Joliet). "He was reluctant to support a cap, but after we met with him several times he recognized the importance of it and would now support a cap of \$350,000. We explained the need for antitrust legislation – how it would affect costs – and he signed on to the Hatch-Archer bill."

Physicians must also continue their work within Illinois for the passage of tort reform, Dr. Kobler said. In 1993, the state Senate passed a bill authorizing a \$250,000 cap on noneconomic damages. However, the bill failed in the

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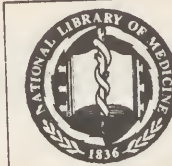


Plans look
for a
good fit

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • OCTOBER 7 1994



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to enact economic
credentialing
legislation

State seeks Medicaid waiver

PROCEDURES: Physicians will be able to sign up for the new program soon. BY JANICE ROSENBERG

[SPRINGFIELD] The Illinois Department of Public Aid on Sept. 14 submitted the new Medicaid reform program, MediPlan Plus, to the federal government for approval. The plan, passed in July by the General Assembly, is aimed at improving the delivery of medical care to 1.1 million of the state's Medicaid recipients and reining in costs by adopting a managed care approach for the state's Medicaid system, according to IDPA.

"We have put Illinois MediPlan Plus, the comprehensive integrated health care system, on the fast track for this fiscal year," said IDPA Director Robert Wright. "The sooner we can implement the system, the sooner the state of Illinois can realize the cost savings and its clients can have improved access to primary and preventive care."

MediPlan Plus was designed to encourage private and not-for-profit groups to join state government in delivering high-quality health care to Medicaid patients while managing costs and allowing recipients to make choices about their medical care, IDPA said.

To implement MediPlan Plus, Illinois must obtain approval from the U.S. Health Care Financing Administration.
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state issues



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addresses
status of
state reform

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Forum focuses on health reform

PANEL: Although congressional leaders conceded Sept. 26 that health reform is dead for this year, the debate continues. BY JANICE ROSENBERG

[CHICAGO] Eight days before Congress abandoned efforts to enact reform this session, federal legislators and professionals from Chicago's business and health care communities gathered to discuss reform.

More than 150 physicians, hospital officials, HMO and PPO executives, health care industry suppliers and insurance company and business representatives attended the Sept. 19 forum on health system reform sponsored by the Chicago law firm Bell, Boyd & Lloyd. Program speakers offered their perspectives on current legislative proposals and discussed the potential consequences if no legislation is passed this session.

U.S. Reps. J. Dennis Hastert (R-Batavia) and Dan Rostenkowski (D-Chicago) opened the daylong program by offering their views on health system reform. Rostenkowski said legislators should take small actions in the remaining days of the session to give themselves a good starting point for next year and prevent the American



Matt Ferguson

During a panel discussion last month, ISMS President Alan M. Roman, MD (right), and Illinois Hospital Association Chairman Gary Mecklenburg discuss their organizations' priorities for health care reform.

public from being disappointed.

"We wasted time looking for a silver bullet," he said. "We should forget perfection and move in incremental steps."

Hastert said members of Congress "need to have better communication with our constituents on this issue. The ones I've talked to have overwhelmingly told me not to pass health reform this year. They said it

was better to wait than to pass a bad bill."

Hastert added that the work Congress completed this year will set the stage for solid debate when reform legislation is reintroduced in early 1995. Despite the lack of consensus in Congress, most legislators agree on some specific reform-related issues, he said. For example,

(Continued on page 7)

ISMS wins accreditation awards

CME: A Society committee receives national recognition. BY TED HARTZELL

[CHICAGO] ISMS' Committee on CME Accreditation has won two of three national awards honoring state medical societies for their work in accrediting sponsors of continuing medical education. The Accreditation Council for Continuing Medical Education presented ISMS with the 1994 Rutledge W. Howard Awards for Meritorious Achievement in Continuing Medical Education Accreditation on Sept. 10. The first-time awards, funded by Merck & Co. Inc., were presented at ACCME's annual conference for state medical societies.

Accepting the awards for the Society was ISMS President Alan M. Roman, MD, who called the recognition a "singular attainment for Illinois."

ISMS and the California Medical Association each won an award for innovative ideas that translate into successful programs, according to ACCME. The second award won by ISMS was for maintaining high standards in its overall accreditation programs.

The Society's Committee on CME Accreditation accredits 60 CME sponsoring organizations, which present nearly 78,000 Category 1 hours per year, Dr. Roman said. Committee Chair-

man John Jurica, MD, said the awards show that through the committee, ISMS is at the forefront of CME accreditation. "Often ISMS' policies and procedures serve as an example for other states. This recognition demonstrates the hard work and dedication of the committee and the staff at ISMS."

The awards were presented by Rutledge W. Howard, MD, whom one speaker called the "godfather" of the state medi-

(Continued on page 8)

CLIA help still available

On Sept. 30, the federal government disconnected the hot line it operated to field questions about compliance with the Clinical Laboratory Improvement Amendments of 1988. But help is still available. Physicians who need information about meeting the requirements of the law can receive assistance by contacting the ISMS department of medical services at (312) 782-1654 or (800) 782-ISMS, ext. 1315.

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Candidates give positions on state issues

Candidates for the Illinois House and Senate recently responded to a questionnaire from the Illinois State Medical Society Political Action Committee. Responses from candidates in key races are provided in the following chart. Incumbents are designated by the symbol (I). Physicians who want more information about candidates may call IMPAC at (312) 782-1963. Members who are unsure of their district may call ISMS' Governmental Affairs Division at (312) 782-1654 or (800) 782-ISMS, ext. 1142.

QUESTIONS

- Caps** – Do you support a \$250,000 cap on the noneconomic (for example, pain and suffering, loss of consortium) portion of damages awarded in medical malpractice cases?
- English Rule** – In medical malpractice litigation, would you support legislation that would require the loser of the case to pay the winner's court costs and attorney's fees?
- Nurse pract. prescribing** – Do you support allowing nurse practitioners to diagnose disease and prescribe medication?
- Optom. therapeutic drugs** – Do you support amending the Optometric Practice Act to allow optometrists to diagnose diseases of the eye and prescribe therapeutic drugs?
- Psych. hosp. privileges** – Do you support allowing psychologists to admit patients into hospitals for nonmedical treatment?
- Motorcycle helmet law** – Would you support a mandatory helmet law for motorcycle drivers and riders?
- Illinois physician licensure** – Would you support Illinois licensure of all physicians who perform utilization review within Illinois?
- Liability** – Would you support statutory liability for utilization review decisions that result in harm to the patient?
- Stand. appeals** – Would you support standardized appeal mechanisms for patients who are denied care?

- = Did not respond
- ▲ = Did not answer question
- ◆ = Needs more information or is unsure

SENATE DISTRICTS

		Caps	English Rule	Nurse pract. prescribing	Optom. therapeutic drugs	Psych. hosp. privileges	Motorcycle helmet law	Illinois physician licensure	Liability	Stand. appeals
29	R- Kathleen Parker D- Grace Mary Stern (I) ●	Y	Y	N	N	N	N	Y	Y	Y
32	R- Dick Klemm (I) D- Michael Walkup ●	Y	Y	N	Y	N	N	Y	Y	Y
35	R- Brad Burzynski (I) D- Lorraine Chaussee ●	Y	Y	N	N	N	N	N	N	N
38	R- Robert Studzinski D- Patrick Welch (I)	Y N	Y N	N N	N Y	N N	N N	Y Y	Y Y	Y Y
41	R- Kirk Dillard (I) D- R. Christine Hotchkin ●	Y	Y	N	N	N	N	N	Y	Y
50	R- Karen Hasara (I) D- Ellen Schanzle-Haskins ●	Y	Y	Y	Y	N	N	Y	Y	Y
53	R- Harry Woodyard (I) D- Charles Mattis ●	Y	Y	N	Y	N	N	Y	◆	Y

HOUSE DISTRICTS

11	R- Charles Stone ● D- Judy Erwin (I)	◆	Y	Y	N	N	Y	Y	Y	Y
36	R- Maureen Murphy (I) D- Nancy Stack ●	Y	Y	N	N	N	N	Y	Y	Y
37	R- Ed Zabrocki, Jr. D- John Sheehy (I) ●	Y	Y	◆	N	N	Y	Y	◆	Y
38	R- Larry Wennlund (I) D- Lois Mayer ●	Y	Y	N	N	N	N	Y	Y	Y
47	R- Eileen Lyons ● D- David McAfee (I)	N	Y	N	N	N	Y	Y	Y	Y
56	R- Carolyn Krause (I) D- Richard Valentino ●	Y	◆	N	N	◆	Y	Y	Y	Y
57	R- Kevin Hanrahan (I) D- Philip Andrew	Y N	Y N	N Y	◆ N	Y N	Y Y	N Y	N Y	Y Y
58	R- Todd Hansen D- Jeffrey Schoenberg (I)	Y ◆	Y N	▲ N	Y N	▲ N	N Y	▲ Y	▲ ◆	▲ ◆
60	R- Edna Schade D- Lauren Beth Gash (I)	Y ◆	Y N	N N	N N	N ▲	Y Y	Y ▲	Y ▲	Y Y
68	R- Ron Wait D- Barbara Giolitto (I) ●	Y	Y	N	N	N	N	Y	Y	Y
69	R- David Winters D- Michael Rotello (I)	Y ◆	Y N	N N	N ◆	N N	N N	Y N	Y Y	Y Y
71	R- Deb Toppert D- Mike Boland ●	Y	Y	N	N	N	N	Y	Y	Y

(Continued on page 14)

IDPR changes complaint procedures

NEW SYSTEM: Individuals may call in concerns. BY TED HARTZELL

[CHICAGO] The Illinois Department of Professional Regulation has changed the procedure by which patients can submit complaints about health care providers regulated by the state, the department announced.

Previously, complaints about licensed professionals or entities had to be submitted to IDPR in writing. But many people were reluctant to state their grievances on paper, said Tony Sanders,

assistant to the deputy director of IDPR. Those who did write often failed to sign their names or provide enough information for the state to investigate, he said.

Citizens may now call the department's Complaint Intake Unit at (312) 814-6910 to express their concerns regarding a regulated professional, IDPR said. Department employees will field calls and ask standard questions designed to elicit the information the

department needs. The employees who staff the line do not investigate; instead, they pass information to investigators, providing them with "more information up front" than previously, Sanders said.

The procedural changes will help IDPR verify the identity of individuals who are the subjects of complaints. That scrutiny will be especially valuable in cases in which several professionals in an area have the same name, he said.

As under the old system, complainants can remain anonymous, he explained. Those who choose to write their concerns may continue to do so. Individuals may also call the Complaint Intake Unit to receive updates on the progress of cases in the investigative or prosecutorial stage, according to IDPR.

The new procedures are a "tremendous step toward ensuring the public's health, safety and welfare in the most efficient manner," said IDPR Director Nikki Zollar.

IDPR is responsible for the licensure and regulation of 44 professions and occupations in Illinois, including physicians. ■

October is Talk About Prescriptions Month

[CHICAGO] For \$5, physicians and other health care providers can buy a resource kit to help them educate their patients and the public about the wise use of prescription medicines.

The education campaign kits are available from the National Council on Patient Information and Education for use during October, which is Talk About Prescriptions Month. This year's theme — communication is good medicine — emphasizes the need for physicians to communicate with patients so that prescriptions are taken properly, the council said.

"Communication about prescription medicines is critical, since 30 to 50 percent of the 1.8 billion prescriptions dispensed annually are used improperly, resulting in prolonged and repeated illnesses, avoidable side effects and drug interactions, repeat doctor visits, increased hospitalizations and even death," said Robert Bachman, executive director of the council.

To spread the word about this year's Talk About Prescriptions Month efforts, the organization conducted its largest-ever direct-mail campaign, sending materials to 175,000 physicians and other health care professionals, the council said. Two of its member organizations, the United States Pharmacopeia and Schering/Key Pharmaceuticals, provided educational grants to pay printing and distribution costs, the council said.

The resource kit includes medicine communication articles, a list of educational resources, radio public service announcements, a sample proclamation, media tips and fact sheets about medication misuse, a poster and a coupon for a \$5 discount on other educational materials offered by the council.

To order a kit, send a check or money order for \$5 to NCPIE, 666 11th St., N.W., Suite 810-M, Washington, DC 20001. ■



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REPORT for Illinois Physicians

ILLINOIS MEDICARE PART B

DOCUMENTATION PROCEDURES FOR ATTENDING PHYSICIANS SUPERVISING INTERNS AND RESIDENTS

In the February and May, 1993, Blue Cross Blue Shield of Illinois (BCBSI) Medicare B Bulletin, the functions of the attending physicians who supervise interns and residents in a teaching setting were clarified. The attending physician must:

- ◆ review the patient's history and the record of examinations and tests in the teaching setting and make frequent reviews of the patient's progress,
- ◆ personally examine the patient and confirm or revise the diagnosis, and
- ◆ determine the course of treatment to be followed.

The attending physician must either perform the services needed by the patient or supervise the treatment provided by interns or residents. In the case of major surgical procedures or complex medical procedures, supervision must be in person and, if necessary, the attending physician must be ready to perform any services performed by the attending physician in a non-teaching setting.

To be reimbursed for an evaluation and management (E/M) service under Medicare Part B, the attending physician in a teaching setting must perform the service personally or be physically present while the service is performed by the resident or intern. Although this carrier realizes it is not practical for the attending physician to be present each time a resident or intern does an initial evaluation or makes rounds, HCFA has pointed out that since resident and intern services are paid to the teaching institution through Medicare Part A, these services should not also be reimbursed to the attending physician through Part B. Therefore, the only E/M services for which the attending physician can be reimbursed are those he or she performs or supervises personally.

Documentation in the patient's medical record must reflect the performance of the attending physician's service in either the physician's writing or by his or her countersignature as the supervising physician. The attending physician must document that he or she personally reviewed the patient's medical history, gave the physical examination, confirmed or revised the diagnosis, visited the patient during the more critical period of the illness, and discharged the patient. The attending physician's countersignature alone is sufficient to justify Medicare reimbursement only when there is documentation in the medical record by the resident, intern, or nurse of the attending physician's physical presence and supervisory involvement when the service was rendered.

(Issue: 10/07/94 - DB)

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EDITORIAL

Illinois sets a positive precedent

Illinois set a precedent on Sept. 16. Gov. Jim Edgar signed a bill making our state the first in the nation to pass legislation protecting physicians from the practice of economic credentialing by hospitals. The new law will take effect Jan. 1, 1995, but to benefit from it, medical staff bylaws must be changed.

ISMS led the fight for physician due process protections after the 1993 House of Delegates meeting. The delegates directed ISMS to introduce legislation mandating a study of economic credentialing by the Illinois Health Facilities Planning Board and requiring hospitals and medical staffs to provide due process procedures. The Planning Board study results were reported to the legislature in January, and now the due process procedures are a reality.

Essentially, the new law revises the Hospital Licensing Act and establishes medical staff credentialing due process requirements. These procedures apply to all hospitals except federal hospitals, the University of Illinois Hospital and Cook County's hospitals. For initial medical staff applicants, the law establishes due process mandates and requires a detailed explanation of economic and noneconomic factors for an adverse decision. For current medical staff applicants, due process procedures include standard written notice of an adverse decision and the right to a fair hearing, record inspection and presentation of witnesses. The

fair hearing panel has independent authority to make recommendations to the hospital board before an adverse decision takes effect. Some exceptions apply to the prior hearing requirements.

The law also calls for 15 days' notice before implementation of any nonrenewal or limitation to medical staff membership or clinical privileges based on economic factors. This will enable physicians and patients to make alternative arrangements for care. Any adverse decisions that relate to staff or clinical privileges and that are substantially based on economic factors must be reported to the Hospital Licensing Board before the decision takes effect. The new legislation also requires the Hospital Licensing Board to study economic credentialing and report its findings to the governor and the General Assembly by Jan. 1, 1996.

To maximize these due process protections, the substance of the new law must be incorporated into medical staff bylaws. Through ISMS' Lawyer Referral Network, members can obtain the legal resources to ensure that medical staff bylaws include the new protections. Members who call (800) MD-ASIST can get a referral to one of more than 70 attorneys statewide who are physician friendly and able to help with legal issues like economic credentialing.

Make sure that your hospital's medical staff bylaws include the basic provisions of the new law.

PRESIDENT'S LETTER

The good in medicine

Alan M. Roman, MD



Physicians are high achievers, voracious readers and tireless workers who set standards of excellence for themselves and others.

Last week's quarterly medical staff meeting in my hospital was probably similar to yours. Unlike the bulletin board in our staff lounge, which serves up the latest clippings on a broad range of physician interests, the meeting offers a front-row seat in the theater of realism, where physicians articulate their concerns, their emotions and sometimes their hostilities regarding local matters.

On my President's Tour, I'm meeting hundreds of physicians. I'm beginning to realize that throughout this great state, physicians are like those who attended last week's medical staff meeting.

Physicians are high achievers, voracious readers and tireless workers who set standards of excellence for themselves and others. They justifiably react negatively to the increasing frustration in medicine. They may not share identical experiences, but their emotions and responses are similar. They are often scared to change, but even more frightened not to do so. They concentrate on delivering high-quality care while nervously glancing over their shoulders, trying to make sense of the looming complex issues.

Admittedly, solutions to these problems do not come easily. But the search must begin with an honest assessment of the reasons we entered medicine and the good in our profession.

Decidedly, the doctor-patient relationship is central to our profession. So let's consider the plight of our patients. To begin with, they don't want to be sick and don't feel well when they go to see their physicians. Not only are they sick, but they're angry at being sick, unhappy with the impersonal system and upset over having to pay for the experience. Physicians are confronted by a knowledgeable public with high, sometimes unrealistic, expectations. They want the best, done precisely, reliably, cheaply and now. Furthermore, some patients' growing skepticism about medicine's ability to remedy their ills and their reluctance to accept responsibility can aggravate an already razor-thin tolerance for imperfection. The same

individual who tolerates long waits in restaurants may complain about receiving similar treatment from a physician.

Sometimes these stresses are enough to cause physicians to re-examine their commitment to medicine. Take a moment to ask yourself why you entered medicine and what is good in medicine today. Like many of your colleagues, you probably entered medicine to make sick people better. You chose medicine because of your love of being with people, the challenge of solving their problems, the gratification of seeing patients improve – patients who are sometimes more grateful than we deserve.

Helping others helps you because it makes you feel better. The animation of a young colleague describing a therapeutic success reminds me that most physicians continue to enjoy what they do. Truly, you can make others better only by being good yourself.

ISMS has a strong reputation as an innovative and successful organization. Your leaders, with appropriate consultants, have been evaluating market trends and Society options to help you adjust to a changing medical marketplace. We're looking for solutions that make the most of the opportunities that differing circumstances and local markets provide us. The best solution will be an approach tailored to your local conditions, incorporating the preferences of local physicians. No one knows medicine better than you do.

We understand that the development of a medical management infrastructure is central to designing a delivery system that expands your options. We recognize you are looking to your Society for help. Results of our feasibility study regarding physicians' options in the marketplace should be available shortly.

Meanwhile, remember why we pursued careers in medicine. Continue to view change with anticipation. And join your Society in overcoming obstacles to a successful doctor-patient relationship and any interferences with your enjoyment of the good in medicine.

Quotables

"Much of the savings that the HMOs wring out of doctors, hospitals and pharmaceutical companies actually goes simply to support the HMOs' overhead and profits, and only a small portion actually flows through to the ultimate payer, which is business and patients."

— **Uwe Reinhardt**, president of Princeton University, Washington Post

"The people in the boardrooms should also be the people in the examining rooms. We want to preserve the doctor-patient relationship."

— **Charles Willey, MD**, a St. Louis physician forming a group with 15 other doctors to compete against large hospital-owned groups, St. Louis Post-Dispatch

"The hospitals want to control physicians in the community, then they can control the flow of revenue."

— **Tom Bennett**, a consultant helping doctor groups compete with hospitals, St. Louis Post-Dispatch

"I won't have to worry about the day-to-day bills or whether the rent is paid. I'll be more into the practice of medicine and less into the business."

— **Paul Schneider, MD**, a St. Louis physician who sold his practice to a hospital, St. Louis Post-Dispatch

"Gun violence is a public health emergency. We have consumer safety regulations that apply to teddy bears. We need regulations concerning gun safety."

— **U.S. Surgeon General Joycelyn Elders, MD**, Chicago Tribune

"Our hands must be untied from the bonds imposed by this law."

— **David J. Walsh**, president and director of the National Association of Insurance Commissioners, about the need for ERISA to be repealed, New York Times

"I don't think anybody is enthusiastic about the balkanization of health care in this country."

— **Deborah Steelman**, former health adviser to President Bush, on the move by states to enact health reform, Health Line



"It wasn't the 12-hour operation today, it was the five insurance forms."

YOCON® YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

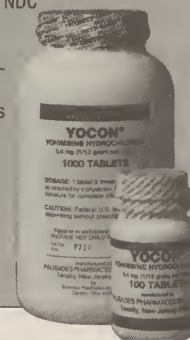
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Tort reform discussed at health care forum

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ISMIE Update



Statehouse candidates'
positions on caps

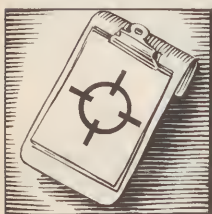
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Case in Point

Managed care complicates follow-up procedures

BY RICK PASZKIET

Tracking patient follow-up can be complex in managed care settings, especially when physicians other than the primary care gatekeeper are involved. As the following case illustrates, doctors should be careful not to assume that patient follow-up is being performed by someone else. Ultimately, that responsibility rests with the primary care physician.



Case #1

THE CASE IN BRIEF: An HMO patient discovered a lump in her right breast and called her primary care physician to report the condition. The physician immediately referred her to a gynecologist, who requested that her primary care doctor order a mammogram. The HMO's protocol required all such tests to be

ordered through primary care gatekeepers.

The mammogram revealed one lesion, and the results were sent to the primary care doctor. However, the physician, who did not maintain any type of follow-up log for outstanding tests, claimed he never received the results of the mammogram and therefore was unaware that it was positive.

The gynecologist also received the patient's mammogram results. But the gynecologist did not follow up with the patient because he assumed the primary care physician would notify her.

A year and a half later, the patient consulted another physician for an unrelated complaint. During the course of the examination, the patient mentioned that she had a breast lump that had grown significantly. She told the physician that she had had a mammogram but that she had never been contacted with the results. This physician recommended a CT scan and a biopsy of the breast, and the tests revealed a malignancy. The patient then received chemo-

therapy and radiation treatments and underwent a radical mastectomy.

The patient sued the primary care physician and the gynecologist for failing to diagnose her breast cancer. The case was settled in favor of the plaintiff.

THE POINTS THIS CASE MAKES: This case demonstrates the importance of patient follow-up by physicians in managed care plans. Although managed care protocol calls for primary care doctors to communicate test results to patients, in the preceding case, the gynecologist should have at least contacted the primary care physician to ensure that the patient was notified of the results.

"Managed care plans have the potential of creating follow-up problems and can be fraught with peril," said Mike Wagner, a Chicago attorney with Baker & McKenzie. "Sometimes physicians make the error of assuming that whoever is doing the billing is also responsible for the follow-up. The bottom line is that you look at the 'duty of care' ordered by the physician—not the billing."

Physicians should not lose sight of their obligations to the patient, Wagner continued. "The managed care structure, with its role of the HMO gatekeeper, doesn't alleviate the burden on the physician when it comes to patient follow-up."

From a physician's perspec-

tive, this case shows the necessity of documenting when test results are received, reviewed and communicated to the patient. "The doctor must take the time to ensure that a patient is called about his or her lab results, especially if the results indicate an abnormality," said Henry Martin-del-Campo, MD, a family practitioner and member of ISMIE's Family Practice Risk Management Subcommittee. "Managed care plans are even more of a challenge to the doctor when it comes to giving the patient prompt communication. The physician has to compensate for the inherent pitfalls of the system."

Physicians can prevent patients from falling through the cracks if they have proper "check-off procedures" in place, Dr. Martin-del-Campo said. For example, a patient's file should remain active until test results are received and discussed by the physician and patient.

"I've always stressed at practice management seminars that the physician should ask himself or herself one important question when it comes to follow-up care: Is there a pattern in the doctor's office of misplaced files or poor patient follow-up? If the answer is yes, then it's the doctor's duty to establish new procedures to correct any deficiencies in his or her patient follow-up," Dr.

Martin-del-Campo noted.

Within managed care, a coordinated effort between the primary care physician and other specialists helps guarantee that the communication necessary for proper patient follow-up won't break down, said Leslie Block, MD, an ENT at Lake Forest Hospital.

"The above case is a classic example of a doctor dropping the ball," said Dr. Block. "The communication lines between the primary care physician and the gynecologist and the patient weren't working. Each wrongly assumed that the other was informing the patient of the test results."

The record-keeping and documentation done by both physicians in this case were not only inadequate, they were nonexistent, Dr. Block said. Neither doctor had any follow-up procedures in place to prevent such a mistake from occurring.

"Physicians have to recognize that there's more room for error in an HMO," explained Dr. Block. "Physicians can't make assumptions about follow-up, and they have to be even more proactive when it comes to patient communication." ■

Case in Point is a regular feature using hypothetical case histories to illustrate loss-prevention maxims.

MALPRACTICE ROUNDUP

Hospital and physicians settle in brain damage suit

A Brooklyn medical center's insurer and several physicians have agreed to pay \$2 million to a 6-year-old boy to settle a malpractice lawsuit alleging that the child suffered brain damage at birth as a result of a forceps delivery.

The plaintiff claimed that the use of forceps on Matthew Lomanov on July 4, 1988, at Maimonides Medical Center caused him irreversible and devastating brain damage, according to an article in the Sept. 19 issue of the National Law Journal. "A c-section should have been attempted. The child has been confined to an institution since birth," said plaintiff attorney Abraham Fuchsberg in the article.

The Aug. 16 settlement of the case of Lomanov vs. Reizis is partially structured, according to the story. ■

Court erred by refusing to hear expert witness testimony

Reversing an earlier trial court ruling, a Kansas appeals court ruled in favor of a patient who claimed his recurrent laryngeal nerve was damaged or destroyed by his physicians during surgeries. The case turned on the lower court's refusal to allow testimony from the patient's qualified medical expert, according to an article in the June issue of Medical Liability Advisory Service.

In Smith vs. Milfeld, the plaintiff claimed the damage to his nerve was sustained during corrective heart

surgery and additional surgery to ligate and cauterize bleeders, the article said. The trial court entered summary judgment for the physicians, and the patient appealed to the Court of Appeals of Kansas.

The appeals court ruled that the trial court had erred by not permitting the patient's qualified medical expert to testify about whether the surgeries deviated from the accepted standard of care. The higher court took note of the expert's statement that he was sure—more than to a reasonable degree of medical certainty—that the physicians damaged or destroyed the nerve and that the damage occurred either during the original or follow-up surgeries, the article reported.

Further, the appeals court said that although the expert may not have based his testimony on a single known action, the conclusions he reached by inferences or logic were admissible. ■

Governor addresses status of state reform

BY JANICE ROSENBERG

[CHICAGO] Speaking to a gathering of Chicago's business and health care leaders, Gov. Jim Edgar said Illinois is progressing on health system reform at the state level.

"Everyone is very concerned about their health and how they're going to pay for their health care," the governor said during a Sept. 19 luncheon address at a health system reform forum sponsored by the Chicago law firm Bell, Boyd & Lloyd.

"For years we hoped that the problems would be solved in Washington. We finally recognized in Illinois that we couldn't wait until Washington acted."

In particular, Edgar noted the problems Illinois has faced in administering Medicaid. The state budget for Medicaid is "out of sight," tripling in the last decade, he said.

To attempt to slow the rapid growth in Medicaid spending, the state legislature in July passed a bill that was prompted by Edgar and that adopts a

managed care approach to Medicaid. "With input from health care professionals and the business sector, we will see a more efficient, effective system in place that will put an emphasis on preventive medicine and early intervention," the governor explained. "We believe it can work and view it as an example of changes in state policy that have come about because we took the time to see what was working in the private sector."

Edgar also expressed concern about the federal government's issuance of mandates for health care professionals. "We need to make sure they're subject to reviews. But those who suggest government should step

in and decide how health care should be provided in the state take away the ability of the doctors and the hospitals to deal with their patients."

The governor also discussed insurance industry reforms he introduced during the recent legislative session. The bill, which failed to advance, called for making health insurance portable, preventing the loss of health insurance through job loss and easing the problems faced by individuals with pre-existing conditions who seek insurance coverage. "We're hopeful that once the [general] election is over, we might get a true hearing on this bill and it might pass." ■

Forum

(Continued from page 1)

there is widespread support that pre-existing conditions should not prevent people from obtaining insurance coverage, that insurance should be portable and that insurance-related paperwork should be reduced, he said. Hastert added that he believes malpractice reform would cut health care costs by decreasing the need for defensive medicine.

Following the Hastert and Rostenkowski presentations was a panel discussion on the consequences of health system reform. In response to questions asked by moderator John Callaway of Chicago public television station WTTW, the panelists voiced varying and sometimes widely conflicting opinions about the necessary elements of health system reform.

Callaway asked panel members what advice they would give President Clinton about reform. ISMS President Alan M. Roman, MD, said he would tell the president that physicians support significant health system reform and a delivery system that puts patients first.

Several panelists pointed to recent changes in the insurance industry and the health care delivery system as indicators that some problems are already being worked out in the marketplace without legislated mandates. Callaway suggested that those changes may have occurred in response to efforts to pass federal health system reform legislation. He asked panelists their opinions on whether the failure to pass a bill would halt further changes.

No, according to Gary Mecklenburg, chairman of the Illinois Hospital Association. He added that most people in the United States are happy with the current health care system and their insurance. Rather than passing a sweeping proposal, lawmakers should help those individuals who have difficulty obtaining medical care and health insurance, he said. Managed care is benefiting the local health care market, he added.

Dr. Roman explained that although physicians support managed care to the extent it allows them to improve the quality of care they deliver to patients, doctors oppose "managed profiteering" and the second-guessing of patient care by managed care "bean counters."

"We're in a battle over who will manage the patients," Dr. Roman continued. "There is a threat to the physician-patient relationship where big managed care groups rule."

The panelists also addressed the issue of funding reform. "You can't add coverage for 37 million people without having the costs go up," Mecklenburg said. "But costs will be brought down by the competitive marketplace." ■



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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.



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Teens’ risk for STDs rising

[RESEARCH TRIANGLE PARK, N.C.] A recent study revealed that teen-agers’ preference for using oral contraceptives is contributing to the rise in cases of sexually transmitted diseases in that age group. The study, conducted by the Alan Guttmacher Institute, found that sexually active young people are twice as likely to use birth control pills as condoms, according to the American Social Health Association, a nongovernmental organization dedicated to the prevention and control of STDs.

“Teen-agers must realize that if they choose to have sex, condoms provide the only protection against all STDs,” said Peggy Clarke, association president. “While the rate of teen-age pregnancy may be stabilizing, the rate of STDs among teens is soaring.”

Teens now have the highest rates of chlamydia and gonorrhea of any age group, and the incidence of STDs is expected to escalate as more teens become sexually active, the association said. One-quarter of the 12 million new

STD infections diagnosed and reported each year occur among teens, who are at higher risk for the diseases than adults for several reasons, according to association statistics. “Teen-age women are more likely to be infected than older women because of biological factors such as an immature immune system,” Clarke explained. “Teens are less likely to know the facts about STDs and have less access to health care. They are also more likely to feel uncomfortable talking about and using personal protection during sexual activity.”

Stressing that most STD infections are symptomless in young women and, if untreated, can cause chronic pain, pelvic

inflammatory disease, ectopic pregnancy and infertility, Clarke said teens need more information. “We must work even harder to educate young people about the relationship between sexual behavior and STDs, teaching them how to protect themselves and how to seek appropriate health care. And we must ensure that young people have access to health care services that provide confidential and comprehensive STD screening, treatment and counseling.”

A new ISMS teen health brochure explains how to avoid contracting the most common STDs and answers frequently asked questions about the diseases. To order copies of the pamphlet, contact the ISMS public relations department at (312) 782-1654 or (312) 782-ISMS, ext. 1303. ■

PRAVACHOL® Pravastatin Sodium Tablets

CONTRAINDICATIONS
Hypersensitivity to any component of this medication.
Active liver disease or unexplained, persistent elevations in liver function tests (see **WARNINGS**).
Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of child-bearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.
WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. **Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals).** Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST, and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see **CONTRAINDICATIONS**). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see **CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism**). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see **ADVERSE REACTIONS**). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper normal limit, was rare (< 0.1%) in pravastatin clinical trials. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with another HMG-CoA reductase inhibitor is increased with concurrent therapy with either erythromycin, cyclosporine, niacin, or fibrates. However, neither myopathy nor significant increases in CPK levels have been observed in three reports involving a total of 100 post-transplant patients (24 renal and 76 cardiac) treated for up to two years concurrently with pravastatin 10-40 mg and cyclosporine. Some of these patients also received other concomitant immunosuppressive therapies. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. Further, in clinical trials involving small numbers of patients who were treated concurrently with pravastatin and niacin, there were no reports of myopathy. Also, myopathy was not reported in a trial of combination pravastatin (40 mg/day) and gemfibrozil (1200 mg/day), although 4 of 75 patients on the combination showed marked CPK elevations versus one of 73 patients receiving placebo. There was a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy (see **PRECAUTIONS: Drug Interactions**). The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination.

PRECAUTIONS
General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see **ADVERSE REACTIONS**). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3 α -hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t $_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin: See **WARNINGS: Skeletal Muscle**.
Antipyrine: Since concomitant administration of pravastatin had no effect on the clearance of antipyrine, interactions with other drugs metabolized via the same hepatic cytochrome isozymes are not expected.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See **DOSEAGE AND ADMINISTRATION: Concomitant Therapy**.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and C $_{max}$ of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The AUC $_{0-12h}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Cyclosporine: Some investigators have measured cyclosporine levels in patients on pravastatin, and to date, these results indicate no clinically meaningful elevations in cyclosporine levels. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, C $_{max}$, and T $_{max}$ for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with aspirin, antacids (1 hour prior to PRAVACHOL (pravastatin sodium)), cimetidine, nicotinic acid, or probucol, no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, ACE inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p < 0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a \geq 50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg/day dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p < 0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p < 0.05). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/– mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See **CONTRAINDICATIONS**.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (Vater association) in a baby born to a woman who took another HMG-CoA reductase inhibitor with dexdramphetamine sulfate during the first trimester of pregnancy. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see **CONTRAINDICATIONS**).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time.

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

Body System/Event	All Events %		Events Attributed to Study Drug %	
	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

* Statistically significantly different from placebo.

The following effects have been reported with drugs in this class; not all the effects listed below have necessarily been associated with pravastatin therapy:

Skeletal: myopathy, rhabdomyolysis, arthralgia.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy, anxiety, insomnia, depression.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, dermatomyositis, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, eosinophilia, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Skin: alopecia, pruritus. A variety of skin changes (e.g., nodules, discoloration, dryness of skin/mucous membranes, changes to hair/nails) have been reported.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Abnormalities: elevated transaminases, alkaline phosphatase, and bilirubin; thyroid function abnormalities.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see **WARNINGS**).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy.

Anemia, thrombocytopenia, and leukopenia have been reported with HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See **WARNINGS: Skeletal Muscle and PRECAUTIONS: Drug Interactions**.)

DVERDOSAGE

To date, there are two reported cases of overdosage with pravastatin, both of which were asymptomatic and not associated with clinical laboratory abnormalities. If an overdose occurs, it should be treated symptomatically and supportive measures should be instituted as required.

Consult package insert before prescribing PRAVACHOL (pravastatin sodium).

(Revised 1-94)

(J4-422E)



Matt Ferguson

Dr. Howard

cal society intrastate accreditation system. Dr. Howard spearheaded creation of the system during the 1960s and 1970s, while working for the American Medical Association.

In the late 1960s, medical schools were feeling pressure to offer CME programs to practicing physicians, a different role for the schools, said Dr. Howard. He began developing an accreditation system that within several years had enlisted medical societies in 50 states, the District of Columbia and four U.S. territories. His working philosophy was to “keep it simple” – freeing the medical societies from excessive paperwork and dealing with them in a “friendly, consultative” way, he said.

It is important for the medical profession to continue relying on a voluntary approach to accreditation, keeping government out of any oversight role, Dr. Howard noted.

Referring to Dr. Howard’s account of developing the system, Dr. Roman said, “Work is seldom work when you enjoy what you’re doing.” That feeling also applies to ISMS’ accreditation program, he added. “A large and dedicated cadre of individuals” is responsible for the work that led to the two awards, he said.

ISMS is a leader in accreditation, said the chairman of ACCME’s Committee on Review and Recognition, George Oetting, EdD. In fact, Illinois was accrediting high-quality educational programs as early as the ’70s, he noted.

A nominating letter from ISMS Board of Trustees Chairman Ronald G. Welch, MD, described the materials and activities on which the two awards were based. They include the annual CME Planners Conference and Surveyors’ Workshop, a handbook for surveyors, a directory of CME sponsors, mock site surveys and videotapes loaned free to sponsors.

In a proposal outlining the goals of the awards, ACCME said public recognition of excellence and innovation in accreditation has been lacking. The organization said it hopes the awards will help publicize high achievements and provide standards for the larger community. ■



MANAGED CARE

Plans look for a good fit

The key to locking up a contract is meeting selection criteria, following guidelines and providing strong 'customer service.'

BY KATHY L. WILKEY

In contracting with physicians, managed care plans look at geography, practice patterns and customer service, according to consultants and plan administrators. In response, some physicians working in managed care settings have expanded their commitment to personal service, said Sandra Gill, president of Physician Resources Management Inc., a health care consulting firm in Westmont. For example, she recalled one of her positive personal experiences with an HMO: "Before the operative procedure, which was done on an ambulatory basis, the physicians and the anesthesiologist called me. They oriented me to the procedure. When I visited the facility, which I hoped I was going to do only once in my lifetime, I was treated with tremendous courtesy and respect. Again, I was oriented after the procedure in the recovery room. They talked to me face-to-face, and then they followed up with telephone contact."

Because of the increasing emphasis on primary care, many plans limit the number of participating specialists. For example, Blue Cross and Blue Shield of Illinois bases the number of specialists in its health maintenance organizations on the number of enrollees, said Arnold Widen, MD, the plan's medical director. "A plan might say, 'We have to get 100,000 more enrollees to add another plastic surgeon to our panel,'" Gill explained.

The demographics within a population or subscriber base may also affect the number of specialists. A region densely populated with individuals of child-bearing age may need more than one obstetrician, while an area with older people may not, said Joanne O'Brien, director of provider services at Rush-Prudential Health Plans.

One year into the joint venture between Rush-Presbyterian-St. Luke's Hospital and the Prudential Insurance Co., Rush-Prudential Health Plans currently has between 6,000 and 7,000 physicians in its three networks, O'Brien continued. That is "way too many" physicians for its nearly 400,000 subscribers, she

added. The plan is evaluating how to shrink its network and how far to reduce it, and geography may be a factor, she said. "Maybe I don't need 15 cardiologists in one particular ZIP code. Our feeling is if we can channel our business to maybe three of them, we can drive a better discount." However, because physician participation in Lake and McHenry counties is low, Rush-Prudential is interested in developing relationships with
(Continued on page 10)



Susan Edison

Managed care

(Continued from page 9)

doctors there, she said.

The focus at Aetna Health Plans of Illinois is on providing multiple choices from which referring physicians can select. To control costs, it relies on primary care physicians to manage the use of specialists, said Thomas J. Main, vice president of health management services at Aetna Health Plans of Illinois. The plans cover about 415,000 people, with nearly half enrolled in network structures like HMOs.

"One criterion is to get a full panel of

specialists within a given service area," Main said. "So, take any given community. If we have the hospitals and a panel of primary care physicians included, in order for that delivery system to work, we need to find two of each type of specialist to cover the full range of services so that primary care physicians have multiple choices of specialists and we have a backup for every specialist."

Many managed care plans have established quality criteria for screening physicians, but most agree that defining quality is difficult. Initially, plans review physicians' credentials, including medical education, residency training, current licenses

and board certification. If plan administrators learn of a malpractice suit or disciplinary action against a physician, it does not necessarily eliminate him or her from consideration, unless the physician was grossly negligent, Dr. Widen said. After finding out about a suit or a disciplinary action, plans follow up to determine the specifics of the case.

DURING THE SELECTION process, plans may also review the physician's employment history. "If it looks like there has been a series of changes in jobs, we may make phone calls to find out why," Main said. If Aetna uncovers a pattern of termina-

tion for a doctor because of quality problems, it may pass over that physician.

Once physicians have contracted with a network, they may be continuously monitored for quality. The Blues and Aetna are able to do physician profiling. "We're watching their practice patterns, their utilization, as one indicator of quality of care," Main said. "We watch readmission rates into hospitals, much of which is driven by the specialists, as another indicator."

In addition, Aetna's involvement with its physicians extends to case management. Nurse case managers follow the course of treatment in large-dollar cases, most of which are supervised by specialists. "Our nursing staff has very thorough and regular involvement with these specialists. So, for example, we're going to know our cardiologists quite well," Main explained.

If any review finds the quality of care to be questionable, most plans have professionals with whom they can consult to determine whether any action should be taken against the physician. "We have an outside panel of physicians that we can pull together to get involved in disputes," Main said. "We will not rule on many of the medical and clinical quality disputes with Aetna people. We'll rule on them through a neutral panel of physicians from the community."

A quality issue could be one reason for terminating a specialist or any other physician. But several other factors can result in termination, including the unbundling of charges, failure to comply with Occupational Safety and Health Administration standards and other regulatory agencies' guidelines, and failure

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to follow plan policies and procedures.

Rush-Prudential conducts periodic site visits to physicians' offices, O'Brien said. "If they have expired medication, we notify them that they have time to make the change. Then we send someone back out." If the problem has not been corrected, a complaint is brought before a committee of physicians and administrators for possible action, she added.

OVERUTILIZATION could also be a factor in contract termination but rarely is. "We would never terminate without having multiple discussions [with the physician]," Main said. "We believe in sharing data with the physician. We believe in education first. But if education and data sharing don't work, we are willing to terminate on that basis."

Dr. Widen said the Blues also uses utilization information to educate physicians, not to discipline them. It sends all

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physicians their own profile reports so that they can compare their performance with the average performance of their peers in the same network. Then they can make any necessary adjustments. The plan is mostly concerned about "distinct outliers," who will be put on probation first, Dr. Widen said. Those numbers are small, with only about 50 physicians out of roughly 8,000 in its Managed Care Network Preferred plan currently on probation.

All plans agreed that customer satisfaction is the most important criterion in retaining or terminating physicians. "We all know you can have a board-certified physician, and he or she might be a full professor at an academic medical center, but he or she [may not] have any bedside manner," Dr. Widen said. "We don't want to have any of those kinds of doctors either." In fact, the Blues surveys its subscribers to determine their level of satisfaction with their provider and their care.

"The members are our customers, and when the members get upset they call us or they go to their employer," O'Brien

said. "If we begin to lose large chunks of business over a particular [IPA] group or provider, we weigh the consequences. Is it really worth having Dr. Jones in our network, or do we need to keep Motorola?"

Cultivating and maintaining a physician-patient relationship may be more difficult under managed care, particularly for specialists. With primary care physicians managing the patient flow, specialists may see patients less often. Patient shifts during annual enrollment periods also result in less continuity of care. To foster a relationship, specialists should make the most of each visit, according to health care consultants. ■



Matt Ferguson

CHILDREN'S ADVOCATE BOB KEESHIN (right), better known as Captain Kangaroo, attends a ribbon-cutting ceremony for the Illinois Department of Public Health's new Cornerstone computer system. Hosting the event were IDPH Director John Lumpkin, MD (center), and Deputy Director Jim Nelson.

Chicago 1993 infant mortality rates released

[CHICAGO] Last year's infant mortality rates for the city of Chicago remained near their all-time low, according to the Chicago Department of Health, which released provisional 1993 rates July 20. The 1993 rate was 13.6 deaths per 1,000 live births. In 1992, the city reached the lowest infant mortality rate in its history, at 13.3 deaths per 1,000 births, the department said.

"Originally, our epidemiologists thought the rate would be even lower than in 1992," said CDOH spokesperson Tim Hadac. "There was a lot of optimism about the numbers. Statistically, the difference is insignificant, but each point represents a certain number of children, so we'd like to see it lower. It steels our resolve to keep going and do a better job next year."

Using 98 percent of the 1993 data related to Chicago births, department epidemiologists concluded that the infant mortality rate appears to have stabilized since reaching its lowest point in 1992, CDOH said. Researchers attributed most of the recent overall decline in infant mortality to reduced neonatal deaths. The mortality rate for newborns has declined 25 percent in the past decade, according to a CDOH fact sheet. Advances in medical technology and the "excellent practice that occurs within Chicago's perinatal centers" account for the lower death rate among newborns, the fact sheet said.

Nearly two-thirds of all infant mortality is associated with low infant birth weight, according to CDOH. At highest risk are infants weighing less than 5 pounds, 8 ounces, the department said. In 1993, Chicago's rate of infants born with low birth weights increased from 10.7 percent to 11.2 percent. However, African-American infants were 2.5 times more likely to be born with a low birth weight than were Caucasian infants. Researchers associated low birth weight with preventable risk factors, such as smoking during pregnancy, a weight gain of less than 25 pounds during pregnancy, inadequate prenatal care and pregnancies spaced less than a year apart, CDOH said. ■

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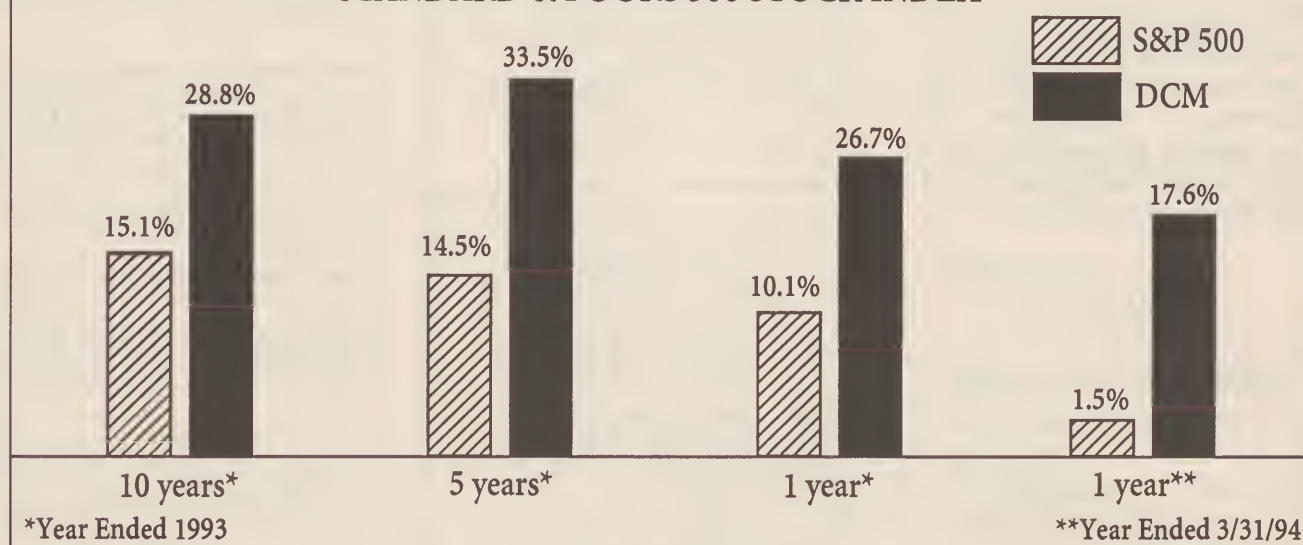
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Obstetrician, EHS Trinity Hospital, Chicago: Pleasant in-house work environment for BC/BE physician. Illinois license, DEA required. Flexible evening and weekend scheduling. Malpractice insurance provided. Please contact Diane Temple, 440 E. Ogden Ave., Hinsdale, IL 60521; (708) 654-0050; fax (708) 654-2014.

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Northern Illinois occupational and urgent care clinic seeks FP, EM or occupational physician for evening and/or weekend coverage. Also seeking full-time physician assistant; competitive salary and excellent benefits. Interested applicants should send CV to David Zweifler, Executive Director, Physicians Immediate Care, 3475 S. Alpine Road, Rockford, IL 61109; (815) 874-8000.

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Candidates' positions
(Continued from page 2)


HOUSE DISTRICTS		Caps	English Rule	Nurse pract. prescribing	Optom. therapeutic drugs	Psych. hosp. privileges	Motorcycle helmet law	Illinois physician licensure	Liability	Stand. appeals
73	R- Jerry Mitchell D- P. von Bergen Wessels (I) ●	Y	Y	N	N	N	N	Y	N	Y
75	R- Stephen Spangler D- Dave Neal ●	Y	Y	N	▲	N	N	Y	Y	Y
80	R- Flora Ciarlo D- John Ostenburg (I) ●	Y	Y	N	N	N	N	◆	◆	Y
89	R- Jay Ackerman (I) D- Grace Bunn Lievens ●	Y	Y	N	N	N	N	Y	Y	Y
94	R- Don Moffitt (I) D- Dora Larson ●	Y	Y	N	◆	N	N	◆	Y	◆
95	R- Rich Myers D- Bill Edley (I) ●	Y	Y	N	N	N	N	Y	Y	Y
97	R- Tom Ryder (I) D- Jerry Montague ●	Y	Y	N	N	N	N	Y	Y	Y

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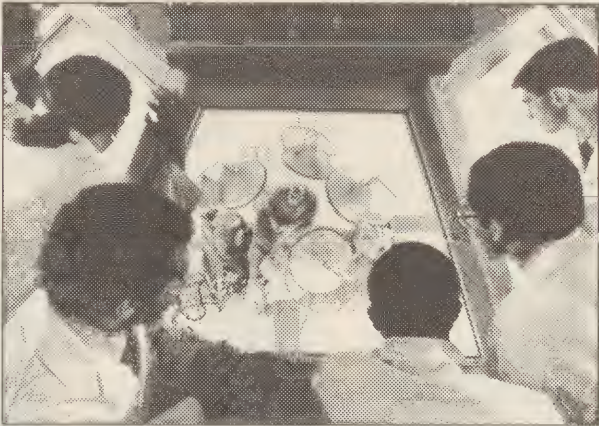
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Medicaid
(Continued from page 1)

Specifically, the state must secure waivers of several provisions of the federal law that governs Medicaid, according to the department. Two major provisions of Illinois' new program require waivers, Wright said. The first waiver would allow IDPA to assign a primary care provider to recipients who do not select one and would lock them into that provider for one year. Under federal law, state Medicaid programs can lock recipients into an HMO for only six months, Wright explained. The second waiver would permit the Managed Care Community Networks developed for MediPlan Plus to serve a client base that is 100 percent Medicaid patients, he noted. Currently, federal law does not allow Medicaid patients to make up more than 75 percent of a capitated entity's total enrollment, Wright added.

To be eligible for those waivers, Illinois must comply with federal regulations that require the state to run MediPlan Plus as a five-year research and demonstration project, Wright said. To receive the waivers, the state must convince the federal government that the results of the demonstration project will be valuable to other states, he said. In addition, at the end of the five-year trial, a university or an outside consulting firm must be hired to complete an independent evaluation of the project.

Without federal approval, the plan cannot be implemented on April 1, 1995, as designed, Wright said. He added that he expects the Clinton administration to alter some of the plan's provisions. But based on discussions with federal officials, Wright said he is confident the plan will be approved so that it can be implemented on schedule.

"While we await final federal action, the state will begin the formal process of recruiting health care groups to participate in the plan," he noted.

In preparation for Illinois Medicaid patients to begin receiving medical services under the MediPlan Plus program, IDPA is taking several interim actions, Wright said. Later this month or in November, primary care physicians in Illinois will receive a mailing detailing the responsibilities of gatekeepers in MediPlan Plus and enabling doctors to sign up. Physicians who participate as

HOUSE DISTRICTS		Caps	English Rule	Nurse pract. prescribing	Optom. therapeutic drugs	Psych. hosp. privileges	Motorcycle helmet law	Illinois physician licensure	Liability	Stand. appeals
99	R- Raymond Poe D- Vickie Moseley (I) ●	Y	Y	N	N	▲	N	N	Y	Y
100	R- Gwenn Klingler D- Marylou Lowder Kent ●	Y	Y	N	N	N	◆	Y	Y	Y
103	R- Rick Winkel D- Laurel Lunt Prussing (I) ●	Y	Y	N	N	N	N	Y	Y	Y
110	R- Ron Stephens (I) D- Robert Daiber ●	Y	Y	N	N	N	N	Y	Y	Y
115	R- Mike Bost D- Gerald Hawkins (I)	Y N	Y Y	N ◆	N ◆	N N	N ◆	Y Y	Y Y	Y Y

gatekeepers will be required to authorize treatment as a basis for reimbursement except in emergencies, according to IDPA.

In December, Medicaid recipients will be asked to choose their providers, Wright said. They will have one month to make their decision. Patients will have the option of choosing a fee-for-service primary care physician, who will serve as a gatekeeper; an HMO; an MCCN or a Federally Qualified Health Center, he said.

If physicians wish to maintain relationships with their fee-for-service Medicaid patients, they should begin talking to those individuals now about the value of

Our goal is to achieve a variety of managed care choices from which clients can select.

continuity in medical care, according to ISMS advisers. Patients who fail to choose will be assigned to a capitated managed care system, the advisers said. Doctors should be prepared to help their patients communicate their selection to IDPA, the Society advisers recommended.

In January, patients' choices will be confirmed, and those who have not chosen a primary care provider will be assigned to an HMO or MCCN by the department, Wright said. Patients electing an HMO or MCCN will be contacted and assigned to a particular site or provider who is already participating in a plan, he said.

Individuals who will be covered by MediPlan Plus include those who are eligible for various IDPA programs, such as Aid to Families with Dependent Children, General Assistance and Aid to the Aged, Blind or Disabled, according to the department. Among the recipients excluded from the program are Medicare beneficiaries, residents of nursing homes and people who must meet monthly deductibles before being eligible for Medicaid, IDPA said.

"Our goal is to achieve a variety of managed care choices from which clients can select and that can provide different approaches for improving access and controlling costs," Wright said. ■

Editor's note: Members of ISMS' Third Party Payment Processes Committee are reviewing the Medicaid plan and will provide updates to physicians through coverage in Illinois Medicine.

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Telemedicine
system to link
patients with
specialists

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Attorney general contest focuses on crime issues

VIOLENCE: Candidates' priorities reflect voter concerns. BY RICK PASZKIET

[CHICAGO] With more Illinois voters concerned about increasing crime, anti-violence initiatives have become the dominant theme in the race for attorney general. Vying for the office are Republican Jim Ryan, DuPage County state's attorney, and Democrat Al Hofeld, a Winnetka plaintiff attorney and former president of the Illinois Trial Lawyers Association.

"An aggressive assault on crime would be my top priority if I'm elected attorney general," said Ryan, of Bensenville. "Illinois voters are worried about the increase in violent crime and want someone in office who has experience in enforcing drug laws, fighting gangs and putting a stop to the surge in domestic violence."

Ryan, who for 10 years has been the state's attorney for DuPage County, Illinois' second largest county, said that he has the necessary experience to combat crime. Ryan's anti-violence program centers around three main goals: "getting tough" with repeat violent offenders, reforming the juvenile justice system and preventing domestic violence.

"During this campaign, I've given anti-crime seminars

throughout Illinois, and one of the overriding concerns voiced by Illinois voters is the need for truth in sentencing," Ryan said. "Basically, we need tougher penalties for offenders, and that means locking the 'revolving' door of prison. Building prisons has to become a higher priority in state spending. But increasing prison capacity does not necessarily mean higher taxes. We have to look at other alternatives, including the privatization of minimum security facilities. This is an area I'll actively explore as attorney general."

There must be more sentencing options for nonviolent crimes committed by juveniles, Ryan said. "The current system has to work smarter. We have to stop kids before they commit violent crimes. By better coordination of prevention programs for juvenile offenders, we can have more success in keeping kids at risk from joining gangs and committing violent acts."

Regarding the final part of his anti-violence program, Ryan said: "As a state's attorney, I have established the state's first child advocacy program and have taken the initiative in protecting the rights of battered

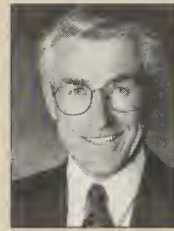
(Continued on page 18)

Governor's race heats up

Edgar puts health issues high on agenda, supports caps

BY TAMARA STROM

[SPRINGFIELD] Physicians will continue to have "somebody they can talk to" if Jim Edgar is re-elected as the state's chief executive, the governor said in a Sept. 28 interview. "We may not always agree, but I think that most of the time we philosophically agree on the approach government ought to take as it relates to health care."



Edgar

But now that Congress has abandoned health care reform efforts for this year, Illinois, like other states, will have to wait and see what might emerge from Capitol Hill next session. Edgar believes, however, that the state can take some actions now such as enacting insurance industry reforms. "I

(Continued on page 18)

Netsch discusses 'high risk' positions, opposes caps

BY RICK PASZKIET

[CHICAGO] Whether she's discussing education, crime or health care, Dawn Clark Netsch said she is not afraid to confront difficult issues in her campaign for governor. "From a political standpoint, I'll admit that some of my positions are high risk," said the Democratic state comptroller. "But I want to give the voters an opportunity to know what I stand for, what my proposals are and how my priorities differ from Gov. Edgar's."



Netsch

One of those differences is her position on the need for tort reform. Although caps on noneconomic damages have been proposed as a way to control health care costs, Netsch

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deliveries
decreasing



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Training office staff to manage managed care

PROCEDURES: Physicians' employees should learn the nuances of insurance plans. BY KATHLEEN FUREORE

[CHICAGO] Ongoing employee training and up-to-date information systems are essential for physicians who want to thrive in a managed care environment, according to health care consultants familiar with the intricacies of operating medical practices.

"You can't run an office in 1994 with staffers who only have a 1984 - or even worse, a 1974 - knowledge and skill base," said Karen Zupko, president of Karen Zupko & Associates, a practice management consulting firm in Chicago. "There are new rules that must be understood, and physicians

must give staff members the opportunity to learn them."

Physicians must ensure that their office staff understand the rules set by each managed care

MANAGED CARE

plan to which they belong, according to Zupko and her associate Sarah Wiskerchen. "The demand on office staffs increases as practices expand into managed care, which means they need more intensive training than ever before," explained Wiskerchen. "The receptionist,

(Continued on page 19)



Carla Sommerfeld

NEARLY 40,000 people participated in the 1994 AIDS Walk Chicago last month. The \$1.3 million raised by the walkers will be used to fund services for AIDS patients.

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HCFA delays approval of Medicaid waiver

REVIEW: The final OK for the new Medicaid plan is at least four months away, according to government officials.

BY KATHLEEN FURORE

[CHICAGO] The Illinois Department of Public Aid is still optimistic that its new Medicaid reform program, MediPlan Plus, will be launched by April 1, even though U.S. Health Care Financing Administration officials said they need at least 120 days to approve the waivers necessary for the program to be implemented.

"We always assumed our waiver request wouldn't be approved until after Jan. 1," said IDPA Director Robert Wright. "But we're confident we'll be able to implement MediPlan Plus by April 1. The question now is, What pre-implementation activities can we pursue while the waiver is going through the approval process at the federal level?"

IDPA representatives will soon meet with HCFA officials to discuss what interim steps are allowable, Wright said. In addition, IDPA will address "procedural issues" raised by HCFA regarding the waiver request, he said, adding that HCFA typically needs answers to some questions when states want to change their handling of Medicaid.

MediPlan Plus, approved by the General Assembly in July, is designed to control costs and improve health care delivery by shifting 1.1 million of Illinois' Medicaid recipients into managed care. IDPA must secure a waiver to assign a primary care provider to Medicaid recipients who do not select one and then lock them into that provider for one year. The department must also obtain a waiver permitting the Managed Care Community Networks developed for the plan to serve a client base entirely composed of Medicaid patients. Currently, federal law

does not let state Medicaid programs lock recipients into a capitated system for more than six months or allow more than 75 percent of a capitated entity's total enrollment to be composed of Medicaid patients, Wright explained.

Although all Medicaid demonstration proposals are reviewed individually and judged on their own merit, there are some basic criteria that are applied in all evaluations, according to a spokesperson in HCFA's Washington, D.C., office. "Generally speaking, we like the plan to be budget neutral. It shouldn't cost more than projections under the existing program," he explained. "We also want to be sure existing Medicaid beneficiaries will continue to have access to good care. We don't want current patients to be shortchanged by a plan to extend coverage to the uninsured."

When the government reviews a waiver application, it considers quality as another important issue, said David DuPre, acting associate administrator of the Chicago HCFA office. "We look at how the state either directly or through providers — in this case HMOs — will assure quality of care."

Most waiver requests take at least four months to review because of the complex nature of such demonstration project proposals, DuPre said. "Very few requests are denied. But most proposals are very complicated. They have to go through a number of offices for review."

"It takes time because we want to make sure the plan meets HCFA standards and also has a chance of achieving what the state wants it to achieve," the HCFA spokesperson concluded. ■



Andrew Halpern

DURING CAREER OPPORTUNITIES DAY for Internal Medicine last month, Hasan Khan, MD (right), discusses an open position at Carle Clinic in Urbana with Donna Jurgens, a clinic representative. The annual event is sponsored by ISMS' Resident Physicians Section, the Illinois Associates Council, the Illinois Society of Internal Medicine and the Illinois chapter of the American College of Physicians.

Flu vaccine recommended for high-risk patients

[HOUSTON] Now is a good time for physicians to administer the influenza vaccine to patients who are at high risk of contracting the illness during the upcoming flu season, said W. Paul Glezen, MD, an epidemiologist for the Influenza Research Center at the Baylor College of Medicine and a graduate of the University of Illinois at Chicago Medical School. Although 1994-95 is expected to be a moderate flu season, physicians "shouldn't miss the opportunity to give the vaccine" to vulnerable patients when they come in for office visits, he said.

Because the flu season normally runs from December to March, Baylor flu experts traditionally recommend that physicians give the vaccination no later than Thanksgiving. But flu seasons can start earlier, so physicians are advised to begin giving the vaccine now, according to Baylor experts.

This flu season promises to be a "B" year, with probably some A in the

spring," said Dr. Glezen, referring to influenza types A and B, which generally occur in alternating cycles. Because the 1993-94 flu season in the United States was dominated by influenza A, influenza B is expected to predominate this year, he noted.

Generally, influenza B is less harsh than type A. People have had more opportunity to build up immunity to type B because its surface proteins don't change as rapidly as do those of type A, Dr. Glezen said.

The elderly and others who are at highest risk for flu complications should get shots every season, he recommended. To help facilitate the vaccination of this large segment of the population, Medicare has been paying for flu shots for people 65 and older since May 1993.

In addition to the elderly, other groups considered to be at the greatest risk for life-threatening complications of the flu are the following:

- Patients with immune system disorders and heart and lung disease, including asthma and chronic bronchitis;
- Patients with diabetes, chronic kidney disease and chronic anemia, including sickle-cell anemia; and
- Health care workers and home caregivers who are likely to have frequent contact with the above individuals.

The vaccine is about 85 percent effective, but it is possible for someone who has been vaccinated to contract a strain not covered by the vaccine, Dr. Glezen said. However, individuals who received shots will have less severe cases than if they had not been vaccinated, he said. In addition, people who receive the vaccine can contract the flu in the two weeks between administration of the shot and the point at which it is fully effective. The vaccine itself cannot cause the flu, because it is not a live-virus vaccine, he explained. ■

Rehab Institute receives top honors again

[CHICAGO] The Rehabilitation Institute of Chicago has been named the top rehabilitation hospital in the country by U.S. News & World Report. Of the five years the magazine has ranked hospitals, the Rehabilitation Institute has won highest honors four consecutive times.

In its latest comparison, the magazine said the ranking was based on a mathematical model that incorporated surveys of national death-rate statistics; data from nine categories, such as the ratio of registered nurses to beds; and physicians' ratings of hospitals. Physician respondents represented a geographic cross section of board-certified doctors in 16 specialties. The mathematical model was constructed by the University of Chicago's National Opinion Research Center.

The Rehabilitation Institute is a private, not-for-profit hospital that includes the nation's largest physical medicine and rehabilitation program. It is one of the biggest centers for the treatment of spinal cord injuries, according to press materials. Besides offering general and specialized rehab services, the institute also conducts research on disabling conditions. ■

PHYSICIAN FACTS

Primary care physicians cite top reasons for poor health among patients¹

	% of respondents
Lack of exercise/sedentary lifestyle	43%
Improper diet or nutrition/too much cholesterol or fat	40%
Obesity/overweight	25%
Too much stress	9%
Alcohol abuse	8%
Not following physician's instructions or prescriptions	2%

¹ Apart from cigarette smoking, not wearing a seat belt and drug abuse
Source: The Life Extension Institute, 1994

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Campaign lengthens list of organ and tissue donors

[CHICAGO] As it approaches its second birthday, Illinois' central registry of potential organ and tissue donors now includes about 1.5 million names.

A \$1-million public awareness campaign, "Life Goes On," helped increase by 50 percent the number of driver's license applicants who signed up as potential donors during May and June, the most intensive months of the ongoing campaign, according to Secretary of State George Ryan's office. During that time, 33 percent of all Illinois residents applying for new licenses agreed to be listed as potential donors, up from 22 percent in June and July of 1993, officials said.

In October 1992, Illinois was one of three states to establish a central registry for donors, using its data base of residents with driver's licenses to track those who agreed to be listed as potential donors, Ryan's office said.

The state spreads the word about

organ and tissue donations to a wide variety of audiences, including civic organizations, the clergy, police, funeral directors and health fair attendees, according to the secretary of state's office. This year, the state also created a donor curriculum for medical students, sponsored its first-ever conference on organ donation and started a training program for license bureau employees.

About 1,700 Illinois residents are on the waiting list for organ or tissue dona-

tions, Ryan's office said. Nationally, one-third of the people on waiting lists – an average of eight a day – die while awaiting transplants, according to press materials. Conversely, an estimated 12,000 to 15,000 Americans die each year under circumstances that would allow their bodies to be used for organ or tissue donations, but donations are made in only about 4,500 cases.

The Illinois registry of potential donors has sometimes made a difference

in identifying a donor in time for a transplant to be performed, said a spokesperson for Ryan's office. In several cases, a procurement agency such as an eye bank has been able to arrange for a transplant because a telephone call to the state data base yielded information that the victim had signed up as a possible donor. "Many times a family doesn't know the wishes" of the victim, the spokesperson said.

For more information about organ and tissue donation, contact the secretary of state's office at (800) 210-2106. To be included in the registry, potential donors may call (217) 785-1444. ■

Health centers receive \$1-million grant

[CHICAGO] Two health centers serving poor residents on Chicago's near north and near west sides will receive a \$1-million boost from the Northwestern Memorial Hospital Foundation, the fund-raising and philanthropic arm of the hospital.

The two sites are the Winfield-Moody Health Center, which serves the Cabrini-Green public housing project and surrounding neighborhoods, and the Erie Family Health Center, which serves West Town and Humboldt Park, according to Northwestern. Under the grant, doctors from the Northwestern Medical Faculty Foundation will staff the centers.

The goal of the grant is to help as many people as possible, said James Glasser, chairman of the hospital foundation's board of directors. "We hope our support will expand access to primary care services and make a real difference in people's lives."

Most of the grant money will be used to fund expanded primary care, including obstetrics, gynecology, ophthalmology and internal medicine, the hospital said. For example, the expanded obstetric and gynecological services will emphasize prenatal care.

Although the grant focuses on primary care, nearly one-third of the funding is designated to provide specialty care to patients who have problems too complex to be treated at the neighborhood centers. "By providing primary care services that are so critically needed in the community, we will inevitably discover an array of more specialized needs that would otherwise not be met," said Jeffrey Glassroth, MD, executive vice president of the faculty foundation.

During the last fiscal year, Northwestern provided more than \$42 million in uncompensated care, including charity care and costs exceeding Medicare and Medicaid reimbursements, hospital officials said. In obstetrics and gynecology alone, the faculty foundation provided care to more than 3,800 women who otherwise could not afford adequate health care. ■



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REPORT for Illinois Physicians

H. E. D. I. S.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET

The Health Plan Employer Data and Information Set (HEDIS) is a core set of performance measures developed to fulfill the needs of employers, as the payors for health care services, and health plans, as the providers of health care services, for a mechanism whereby the quality performance of a health plan can be evaluated and compared to that of other health plans. HEDIS allows the employer to know what "value" the health care dollar is purchasing. HEDIS can be used to hold a health plan "accountable" for its performance, and to trend that performance. Furthermore, HEDIS can assist health plans by providing a common set of reporting standards that will satisfy multiple users of the health plan.

HEDIS is only the first step in developing a system of comparable performance standards. The intent is to continually revise and improve the measures; therefore, HEDIS is a dynamic process. The selection of HEDIS performance measures was based on three criteria: (1) relevance and value to employer, (2) the ability of health plans to collect the specified data; (3) the potential of the measure to actually improve health care delivery.

HEDIS was developed as the result of the combined efforts of health plans and employers. The undertaking was first organized by a coalition of group and staff model HMO's who were joined by four large employers. Four months later, Kaiser-Permanente joined the effort. The first edition of HEDIS, HEDIS 1.0, was completed in September, 1991. The document was then given to the National Committee for Quality Assurance (NCQA) for revision and improvement. NCQA established a Performance Assessment Committee (PAC), and the PAC added additional employers and insurers. The PAC's review began in October, 1992, and was completed in May, 1993. The second edition of HEDIS, HEDIS 2.0, was published in November, 1993. NCQA now includes as part of its evaluation process of health plan, their ability to collect HEDIS 2.0 data. One of Blue Cross Blue Shield of Illinois' (BCBSI) managed care products, Managed Care Network Preferred (MCNP), will be undergoing the NCQA evaluation process in December, 1994; consequently, BCBSI is committed to establishing the capacity to collect HEDIS data.

HEDIS addresses 5 major areas of performance: (1) Quality, (2) Access and Patient Satisfaction, (3) Membership and Utilization, (4) Finance, and (5) Descriptive Information on Health Plan Management and Activities. In the area of Quality, which is of most interest to BCBSI network physicians, the actual performance measures are the following:

Preventive Medicine	• Childhood Immunizations • Cholesterol Screening	• Mammography Screening • Cervical Cancer Screening
Prenatal Care	• Low Birth Weight	• Prenatal Care in First Trimester
Acute and Chronic Disease	• Diabetic Retinal Exam	• Asthma Inpatient Admission Rate
Mental Health	• Ambulatory Follow-Up After Hospitalization for Major Affective Disorders	

Therefore, the Quality Management program of BCBSI is committed to determining the status of these indicators of the quality of care in BCBSI's physician networks.

(Issue: 10/21/94 - ALW)

Telemedicine system to link patients with specialists

TECHNOLOGY: Southern Illinois University is implementing a video network to improve access.

BY JANICE ROSENBERG

[SPRINGFIELD] This fall, the Southern Illinois University School of Medicine will initiate a telemedicine network in cooperation with Ameritech. The network will provide real-time, two-way video, voice and data transmission to connect medical and educational facilities in Springfield and Carbondale. It will allow physicians, patients, researchers, administrators and educa-

tors to exchange information face-to-face without traveling long distances, according to SIU officials.

The network's ability to connect doctors in rural settings with specialists in Springfield is exciting, said Michael Pfeifer, MD, associate professor of medicine at SIU. "When you're a family practice doctor in a rural area, you feel isolated. It will be nice to know you can

call and talk to colleagues, run a case by them, show X-rays and EKGs and get quick feedback. Then you can decide if the problem can be handled locally or if it needs more expertise."

Currently, rural patients who are referred to specialists in larger cities such as Springfield must travel more than an hour each way. "You hate to send someone to see a physician three hours away unnecessarily, but you want to catch problems as early as possible," said Dr. Pfeifer. "Telemedicine will give physicians the chance to intervene at an earlier stage."

SIU physicians have demonstrated consultations for such conditions as a foot ulcer in a diabetic patient. The seriousness of the patient's condition would

likely warrant a referral to a specialist, Dr. Pfeifer said. "In a case like this, the primary care physician would have wanted to know if the infection was likely to become osteomyelitis and how to treat it. My being able to see it on the network would have saved the patient a trip to Springfield."

Once the network is fully operational, primary care physicians and their patients in the southernmost areas of Illinois will be able to go to Carbondale for consultations. Future expansions could link other communities in southern and central Illinois to Springfield, according to SIU.

"This will bring our graduates or any doctors who are isolated back into the fold by allowing them to stay in touch with specialists here [in Springfield]," said Richard Hendee, SIU's assistant dean for communications.

During the telemedicine consultations, specialists in Springfield will use electronic stethoscopes and bidirectional Doppler systems to perform long-distance examinations of the patients in

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

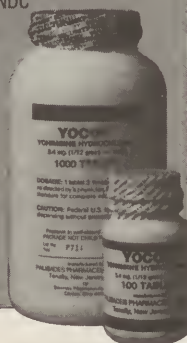
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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Cesarean deliveries decreasing

STATISTICS: Cost Containment Council releases survey.

BY ANNA CHAPMAN

[SPRINGFIELD] The number of cesarean sections performed in Illinois between 1990 and 1992 declined by 5.2 percent, according to a report on 1992 cesarean and vaginal deliveries recently released by the Illinois Health Care Cost Containment Council. Of the 180,366 deliveries in Illinois in 1992, 140,833 were vaginal and 39,533 were cesarean, an executive summary of the report stated.

The state's c-section rate fared well compared with the national rate, the study revealed. In 1992, the c-section rate in Illinois hospitals was 21.9 per 100 deliveries.

"The cesarean section rate has begun to drop slowly and steadily in Illinois," said John Noak, executive director of the council.

The report also showed a 7.1-percent decrease between 1990 and 1992 in the average length of stay for women having babies. In 1992, the average stay was 4.2 days for cesarean deliveries and 2.2 days for vaginal deliveries, the summary noted.

Despite decreases in the length of OB hospital stays, average charges increased by 13.4 percent for cesarean deliveries and 15.5 percent for vaginal deliveries, according to the summary. Charges in 1992 averaged \$3,271 for vaginal deliveries and \$7,039 for c-sections, the study showed.

"There are several reasons for these increases, including the changing characteristics of women who are having babies," Noak said. "Today's women are older. We've also seen a substantial increase in the use of technology in obstetrical departments." In addition, Noak listed increases in the price of supplies and pharmaceuticals and in overall health care costs.

Cost containment is not the only reason the state is trying to reduce c-section deliveries, Noak said. "It's not just the dollars but the quality of care we're concerned about. A c-section is a very invasive procedure that involves a certain amount of danger. A vaginal birth is preferable if at all possible." However, c-sections should be performed when

they are medically indicated, he noted.

The council did not determine which hospitals performed more c-sections because their patients were at higher risk, Noak said. "The report lacks an adjustment for severity, which we hope to include next year." That adjustment could help explain wide variations in c-section rates among regions of the state, he said. The higher c-section rates found in Madison, Clinton, St. Clair and Monroe counties — which reached 32 percent — may also be due to regional practice differences, he said. Chicago had the lowest rate, at 19.5 percent.

"Any hospital with a rate in excess of the state average ought to take a look at what they're doing [to] see if there is a good reason for [the higher rate]. If not, there are things that can be done," Noak said.

He cited Mount Sinai Hospital Medical Center in Chicago as an example of a facility that reversed a rising c-section rate. He called that hospital's program "one of the best campaigns in the state" to help decrease c-sections and focus on prenatal care.

"What success we've achieved is a change in attitude among providers as to when to intervene," said Stephen Myers, MD, director of the maternal/fetal unit at Mount Sinai. The c-section rate reduction program began in 1986, and two years later the hospital's rate declined from 17 percent to 11 percent, where it remains, Dr. Myers said.

The hospital did not implement rigid policies or punitive measures to lower the rate, he explained. Instead, through a quality assurance program, the hospital developed practice profiles for each physician, which were shared with their colleagues. "We took the attitude that we were dealing with professionals who knew what good care was. [They] understood that they were being monitored and modified their own behavior."

To lower c-section rates, physicians and patients must be educated, Noak said. "It should be a cooperative decision based on fact, not on convenience." ■

Carbondale. Some people have expressed concern that telemedicine will be impersonal, but the presence of the patient's primary care physician during all consultations means the patient will not sit alone in a sterile environment staring into a camera, officials said.

In addition to providing clinical connections, the network is expected to provide physicians in rural communities with continuing medical education based on actual patient and clinical concerns, said Carl Getto, MD, SIU medical school dean. "We're always looking at ways to bring education to the places where physicians practice, and we hope to use telemedicine for that purpose," said Dr. Getto.

ISMS House of Delegates policy supports the development of telemedicine technology in Illinois, encourages cooperative efforts among telemedicine technology users, directs the Society to monitor the appropriateness of telemedicine in addressing access and confidentiality concerns, and urges the state to help fund those initiatives at suitable academic centers.

AMERITECH **WAIVED** the nearly \$1-million cost for the Carbondale-Springfield telemedicine link. After the first year, the equipment, valued at \$800,000, will belong to SIU, Hendee said. For the current link-up, line charges will run about

\$50,000 per year and maintenance fees about \$30,000, he said. Future sites are estimated to cost \$100,000 each.

As for physician reimbursement, Dr. Pfeifer said: "It's nice to think we could do [consultations] gratis, but that's not feasible. If we're going to take an hour or two a day to do these consultations, it's important that we can recoup the expenses. Right now, reimbursement is up for grabs. HCFA wants to know how [telemedicine] will be used. Will it be cost-effective? Will it save money?"

Currently, Georgia is the only state with an approved reimbursement code for telemedicine charges incurred through a system run by the Medical

College of Georgia, Dr. Pfeifer said. Pending HCFA approval for reimbursement of government-paid patients, the network will initially be used for patient education and administrative conferences, he added.

The network may also eventually be used to examine inmates of Illinois prisons, Dr. Pfeifer said. On-site equipment would be expensive, but money would be saved on prisoner transportation, he added.

"The more we think about how we can use this, the more we can expand on it," said Dr. Pfeifer. "The capabilities are bounded only by our imagination." ■

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Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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EDITORIAL

Boosting preschool immunization efforts

The smallpox virus seems headed for extinction. The last remaining stocks of the virus are scheduled to be autoclaved to death on June 30, 1995, reported the New York Times. All that's needed is for a unanimous recommendation by a World Health Organization committee to be seconded by the agency's full membership. Apparently, the risk of the virus' use in biological warfare was one of the deciding factors in the committee's decision.

Smallpox was declared eradicated in 1980 – one of the greatest triumphs in public health. But we haven't been quite so successful in wiping out other viruses and diseases, which is one reason immunization is so important.

Immunization levels for U.S. infants are not meeting recommended levels, according to an article in an October issue of JAMA. A study cited found that only 46 percent of Caucasian infants and 33 percent of African-American babies had completed the recommended primary vaccine series in their first seven months. The researchers said that a major reason for low preschool immunization was "missed opportunities," including inappropriate contraindications like minor illnesses. They found that parental education offset related risk factors such as low income.

Even offering free vaccines to children doesn't necessarily guarantee they will receive adequate immunization cover-

age, said another JAMA article. Researchers in one study found that despite availability of free vaccine to most patients, only 67 percent had received their first set of immunizations by three months of age, and only 29 percent were up-to-date by seven months of age. Infants were considered properly immunized if they had received one diphtheria, tetanus and pertussis vaccine, and one polio vaccine by 90 days after birth and if they received three DTP and two polio vaccines by 210 days after birth. The researchers recommended that information and tracking services should be developed to identify children with delayed immunizations.

In the last 100 years, immunizations have dramatically reduced the number of reported cases of such diseases as diphtheria, measles, mumps, pertussis, poliomyelitis, rubella and tetanus, said the AMA's Council on Scientific Affairs. But those scientific advances won't benefit children who aren't properly immunized.

Universal access to free immunizations is not yet a reality. But as JAMA reported, the availability of free vaccines doesn't ensure that children receive the recommended shots. To achieve widespread vaccination, we must also educate parents about the importance of immunizing their children and about the specific vaccines needed. Let's make immunization a public health and an individual priority.

PRESIDENT'S LETTER

Make wishes and dreams come true

Alan M. Roman, MD



We are not providers, entrepreneurs or even gatekeepers. We care more about our patients than our pocketbooks.

Now I lay me down to sleep, I pray the Lord my soul to keep." Eight-thirty means bedtime prayers for my children, Justin and Lindsay, and reflection with Mom and Dad on the activities of the day. It provides an opportunity, in the words of vocalist Whitney Houston, "to show them all the beauty they possess inside; to give them a sense of pride, to make it easier. ..." Yes, more than a recap of the day's highlights, bedtime is a chance to instill pride in our children.

Pride can be difficult to express, but we all know the feeling. Pride is a personal commitment and a delight in our accomplishments. It separates excellence from mediocrity. And while there may be no more vibrant pride than what we have for our children, our pride in medicine is no less real and not far behind.

Medicine has a tradition of being sacred, loving and caring. The profession has long provided great opportunities for those who commit themselves and work hard. Physicians are revered and oftentimes pillars in their communities. Our profession provides the opportunity to work beside other caring people – some of the most intelligent and stimulating individuals anywhere.

Other satisfactions abound. There is the gratification of having pleased our patients, just because we are willing and eager to do so. Educational and technological advances excite us, and the opportunity to take care of sick patients – regardless of their circumstances – enriches us. The compassionate treatment of those who have fallen on hard times expresses our devotion as much as our education.

Medicine implies a commitment to high ideals and self-policing. The pursuit of material gain is not a primary goal of our profession. We are not providers, entrepreneurs or even gatekeepers. We care more about our patients than our pocketbooks.

Our defining moment comes in selecting the best treatment for a patient and seeing the maximum outcome evolve. It still puts a lump

in my throat and brings tears to my eyes when a trusting colleague sends patients with serious illnesses to me – patients whom I then guide through a difficult operation and a return to a healthy life. You too have been there before. No CPT code describes the feeling.

Granted, patients today are different than when I entered practice 15 years ago. Most patients were older than me then, but there was a more pervasive sense of trust. Today, patients are more educated, sometimes less accepting, occasionally wary of a hidden agenda. But most are still very grateful.

Our enemy is not government or insurance companies or attorneys, but the pain of human suffering. Our every thought should be for our patients. Be proud of your profession and your contribution. Combating pain is our greatest challenge and our greatest reward.

Continue your high expectations. Those who expect little from themselves should not be surprised if they amount to nothing. What you are shows in what you do. Your daily thoughts reflect the essence of your character and your professional pride. That pride is the best possible preparation for our success.

Occasionally, I hear from doctors who have discouraged their children from being physicians. That disturbs me deeply, for a smart generation is at risk of breeding a smarter generation of individuals who will not know what to do with themselves. Remember, the practice of medicine also affects parental behavior and deeply influences our offspring.

My son, Justin, a second-grader, was given an assignment that asked what he wants to be when he grows up. He wrote:

"I want to be a dokder.

I will work at a hosptel.

I want to do the job because my dad das it!"

What more could a father ask for? What a simple expression of pride. "And may all my wishes and dreams come true. Amen."

LETTERS

Does the ADA limit doctors' rights?

The article "HIV treatment rulings are a wake-up call for physicians," published Sept. 23 in *Illinois Medicine*, raises some interesting questions.

First, does the Americans with Disabilities Act fundamentally change the concept of freedom of choice for physicians, such as a doctor's right to choose whom to treat, except in emergency situations? Second, does the ADA affect a physician's right to recommend the therapy he or she believes is suitable for each patient?

If we look at the scientific aspects of the Rodney Tvinger case, it is obvious that the photoluminescence therapy requested by Tvinger for AIDS treatment is a controversial procedure with questionable results. The physician who performed such therapy apparently used it for patients with hepatitis B infections, not AIDS. Therefore, he would not have known whether the treatment would be effective or what complications might arise if it was administered to a patient with compromised immunity.

Do patients have the right to decide what treatment they should receive, even if that treatment has been used only experimentally for other diseases and has not been tried for their particular disease, and therefore is of unproven effectiveness? In their quest to receive such treatment, patients now appear to have an ally in the courts, which can force physicians to render such treatment.

Physicians are bound by the Hippocratic Oath to "do no harm." But does that tenet apply to the courts as well?

— Biswamay Ray, MD
Chicago

Abortion opposition contrary to science

The letters to the editor in the Aug. 26 issue perpetuate a falsehood that is based on religious interpretation but that is contrary to science and medicine. In their opposition to physician participation in abortion, the authors rely on the old debater's trick popularized by the Catholic hierarchy and the fundamentalist religious right: Set up a straw man and then limit the debate to attacks on that straw man.

Although scientifically a fetus is far removed from being a baby and although the Bible is totally silent on the subject of abortions, the ayatollahs of the Christian Hezbollah (the party of God) must find a way to equate the cells of a fetus with a living human being so as to apply to them the second commandment, "Thou shall not kill." They do this by inventing a straw man, the false and nonexistent baby, and using this faulty reasoning to coerce others into adopting their own religious interpretation.

It is unfortunate that the editors of *Illinois Medicine* gave a forum to such religious diatribe under the guise of debating the Hippocratic Oath, an oath that swears "by Apollo the physician, by Aesculapius, Hygeia and Panacea," and that is witnessed by all the gods and goddesses. That is an oath most physicians never took.

— T. Shelly Ashbell, MD
Chicago

Permit participation in executions

I noticed two letters regarding abortion and execution in the Aug. 26 issue of *Illinois Medicine*. The letters argued that if Illinois doctors are not permitted to take part in the executions of criminals, they should not participate in abortions either.

I strongly agree that doctors should not perform abortions, but I strongly disagree that Illinois doctors should not be allowed to assist in criminal executions. When a criminal commits a crime worthy of a publicly sanctioned death penalty because of his or her inability to exhibit respect for decency in society, we have a right to participate in the execution in some capacity. It was the criminal who decided his or her own fate, not society. He or she is the one who elected to commit those heinous acts. On the other hand, a fetus has done nothing detrimental, and in fact, we don't know what potential benefit that individual would have had to society. Does that fetus deserve to die?

Therefore, leave the innocent life of a fetus alone. And if society mandates a death penalty for heinous crimes, doctors should be allowed at least to pronounce the criminal dead following an execution if they so desire.

— Jerome Klobutcher, MD
Chicago

Performing abortions is hypocritical

I want to express my appreciation for the publication of the two letters in the Aug. 26 issue from individuals who, like myself, are appalled at the widespread slaughter of unborn babies across America. I am convinced there is a vast number of physicians who also feel similarly about what the "abortion crowd" is doing, even though they don't write about it. It is unfortunate that this slaughter goes on with the approval and blessing of some members in the medical profession. It is even the official position of the AMA.

As was so well-expressed in the letters, physicians who take the Hippocratic Oath and then freely perform abortions become hypocrites, since the oath says "do no harm."

— Norbert Weber, MD
Chicago

Illinois Medicine reserves the right to edit all letters for publication.

GUEST EDITORIAL

Are medical specialists really the problem?

By James Frakes, MD

Recent news articles have highlighted the role of generalist physicians in managed care and other health care reform schemes. At the same time, the importance of specialists largely has been ignored. Moreover, specialists often have been blamed for the high cost of medical care.

Medical specialists are not the problem with American medicine. They are a vital part of its remarkable reputation for excellence. As policy-makers and the public consider health care reform, they should carefully weigh the integral role of specialists in delivering quality care.

Why are specialists perceived as the bad guys in health care reform? The conventional wisdom is that there are too many, they are too expensive, perform too many tests or procedures and are somehow less caring than generalists. That view has gone unchallenged for so long it is almost regarded as fact. It has even led some to suggest restricting the career choices of physicians, promoting broader patient care activities by generalists and limiting patient access to specialists.

I think there is a more responsible view of specialists.

Specialization is a natural evolution in medicine, as in most professions. It advances knowledge and elevates the level of practice. Patients with difficult problems have been the beneficiaries of this evolutionary process. Specialists in large part have been responsible for the advances in medical science, the high standards of medical education and the high quality of patient care in the United States. They are also most likely to be the leaders in medicine's future successes.

Excellence in medical science and practice cannot be achieved if there are inappropriate reductions in specialty training programs, inadequate funding for research in specialty medicine and unreasonable barriers between patients and specialists.

How can the need for specialists be balanced with that for cost containment? As recently stated by the Association of Subspecialty Professors, specialty care "should be made more affordable, not less available." For example, physician payment should be reformed to narrow the gap between generalist and specialist incomes. Specialists should be used primarily for difficult diagnostic and management challenges and for special technical skills. Even coordinating patient care, traditionally viewed as a primary care task, is sometimes best handled by specialists, particularly for patients with

complicated chronic illnesses. In addition, only physicians with proper training and certification should function as specialists. Thirty percent of physicians who train for a specialty beyond internal medicine never achieve certification. But many claim to be specialists anyway, which contributes to the perception that there are too many.

The assertion that specialists provide too much care is not well-supported. In fact, some studies have shown that in some clinical situations early referral to a specialist may be the most efficient and cost-effective course. Excessive care is difficult to define, and the perception about it may result from honest differences in medical judgment. Defensive medicine may also contribute to some increased testing by specialists, since courts hold them to a higher standard of care.

The technology used by specialists is often criticized for its cost. Although it is expensive, the proper use of technology may reduce spending for less-accurate and less-effective services. The effect of technology on quality of care must not be ignored. Patients benefit in many ways from technological advances — through earlier diagnosis, reduced pain, shortened recovery time, better functional outcome and improved general health. Concerns about overutilization and appropriateness of care can be addressed through the development and implementation of practice guidelines. Those guidelines, however, must be based on medical standards of care, not solely on costs.

To lower costs, many managed care organizations are using "gatekeepers" to restrict patients' access to specialists. Those gatekeepers are often subjected to financial pressures that discourage referral, which could ultimately lower the quality of care patients receive. The creation of such financial disincentives for appropriate referrals is unethical. If the health care system is to be safe and

cost-effective, generalists and specialists must be appropriately accessible.

Payment reform, appropriate use of specialists, rigorous credentialing and practice guidelines all would reduce the cost of specialty medicine and preserve access to those highly trained physicians. Specialists are just as caring as generalists. Caring is a quality of any good physician and is not limited to primary care.

Specialists are not the problem. They are an essential part of any quality health care solution.



Dr. Frakes is a board-certified specialist in gastroenterology in Rockford and a clinical associate professor of medicine at the University of Illinois College of Medicine at Rockford. He is also an ISMS member.

*Suit alleges girl
contracted HIV
from vaccine*

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ISMIE Update

**Gubernatorial
candidates
discuss caps**

PAGE 1

Insurer's solicitation draws fire from ISMIE

COMPLAINT: A competitor is using deceptive information about insurance ratings to attract policyholders, according to ISMIE. BY KATHLEEN FURORE

[CHICAGO] ISMIE has filed a complaint with the Illinois Department of Insurance against a company it contends used misleading information to lure new policyholders. At issue is a letter of solicitation sent to ISMIE policyholders with a copy of Martin Weiss' Safe Money Report, which listed ISMIE among the country's weakest medical malpractice insurers, according to an ISMIE spokesperson. The mailing was initiated by the Cunningham Group, the Illinois representative for The Doctors' Co., a California-based professional liability carrier.

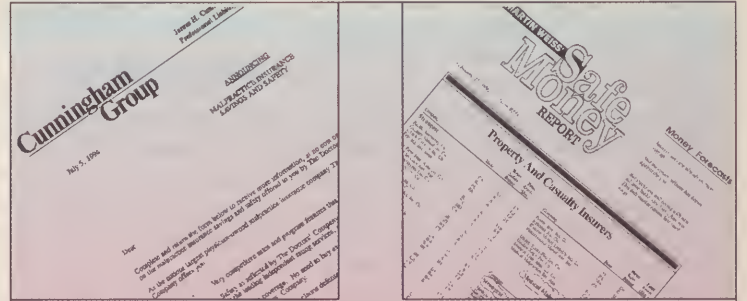
The Weiss insurance ratings are "misleading and highly controversial," and the Cunning-

ham Group's use of the Weiss report constitutes a "serious and intentional misrepresentation of ISMIE," said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. Florida-based Weiss Research, which began issuing property and casualty ratings last year, gave ISMIE a safety rating of D and gave The Doctors' Co. an A-, the ISMIE spokesperson said.

ISMIE officials believe that the Cunningham Group letter violates a section of the Illinois Insurance Code that prohibits the use of misleading representations or comparisons of companies to induce policyholders to change insurers, Dr. Jensen said. The code also forbids the

"issuance, circulation or knowing creation" of material that contains false or malicious statements intended to harm the reputation of a company doing business in Illinois, he explained.

"Many large insurance companies rated favorably by A.M. Best and Standard & Poor's have received questionable ratings from Weiss," Dr. Jensen noted. He cited a 1993 article in National Underwriter stating that Weiss issued D ratings for such companies as U.S. Fire Insurance, the Insurance Co. of North America and the Industrial Indemnity Co. of California, even though those companies earned top marks from A.M. Best. "The secrecy that sur-



ISMIE's response

The Cunningham Group's use of the Weiss report constitutes a "serious and intentional misrepresentation of ISMIE."

"The way Weiss assigns ratings is unclear."

ISMIE has consistently received "solid marks" on National Association of Insurance Commissioners tests designed to measure insurers' financial security.

rounds the development of the Weiss product makes it a pig-in-a-poke rating," said Warren Levy, assistant vice president of Cigna, in the National Under-

writer report.

"The way Weiss assigns ratings is unclear," Dr. Jensen said. "We've requested infor-

(Continued on page 10)

MALPRACTICE ROUNDUP

Amniocentesis caused baby's facial paralysis

The South Carolina Supreme Court upheld a jury verdict finding that a physician's faulty handling of an amniocentesis caused facial paralysis in an infant, according to an article in the Malpractice Reporter. The jury awarded \$625,000 to the child and the parents, but the trial judge lowered the amount to \$350,000, said Edward L. Graham, an attorney for the plaintiff.

Defendant Mary Blanchard, MD, performed the amniocentesis four days before the scheduled delivery date of the plaintiff, a diabetic who had complained of reduced fetal activity, the article said. Less-invasive tests, including fetal heart monitoring, indicated the baby was active and healthy, but Dr. Blanchard said she believed the amniocentesis was necessary because of the mother's complaints and the presence of gestational diabetes. The test was conducted to obtain a sample of amniotic fluid to determine the development of the fetus' lungs. If they were adequately developed, an early surgical delivery would be performed.

Dr. Blanchard testified that she inserted the needle into the woman's abdomen twice, the article said. She said she aimed for the back of the fetus' head and moved the needle around inside the amniotic sac in search of fluid. In addition, she said that she struck the fetus several times with the needle but that she did so on the left side of the head, the article noted. The paralysis occurred on the right side of the infant's face. Dr. Blanchard was not able to aspirate amniotic fluid, but some blood was aspirated, according to the story.

Documentation about the two bloody taps and three wounds on the back of the baby's neck were considered at the trial, Graham said. Although individuals testified about wounds to the right side of the baby's head, no clear-cut proof of wounds in that location existed, he added. A vital piece of information was revealed when the infant's right eyelid wouldn't close—a symptom of facial nerve damage, he said.

The state supreme court said a reasonable jury could have inferred that the needle struck the right and left sides of the baby's head, according to the article. ■

Courts loosen restrictions on impact rule

In medical malpractice cases, courts have long observed the "impact rule," which bars an individual from recovering damages for fright, nervous shock or mental or emotional distress unless the person has also suffered a physical injury or impact. But application of the rule is softening as courts create limited exceptions, according to an analysis of recent cases reported in Medical Malpractice Law & Strategy.

Plaintiffs are experiencing the most success in claims about the fear of AIDS, the article noted. Those types of cases usually fall into two categories. The first involves patients who have been wrongly diagnosed as having AIDS and who have sued for emotional damages stemming from that erroneous belief. The second involves plaintiffs who believe they may have been exposed to HIV in a medical setting and who sued for damages based on fear of contracting the disease.

Courts are increasingly willing to consider a plaintiff's "zone of danger," the article explained. For example, if the plaintiff was not physically harmed but perceived the potential for harm, a court might allow the individual to sue for emotional distress caused by another person's intentional or negligent activity.

A different aspect of this principle is at work when courts permit lawsuits by people who themselves were outside the zone of danger but who witnessed an accident that caused serious injury to a close relative, the article noted.

Yet another factor in increased lawsuits based on emotional distress was acknowledged by a Delaware court. Its ruling stated that medical science has made great strides in tracing the source of later injuries in instances of fright or nervous shock.

Although some courts may be more receptive to such claims, most have limited their scope, the summary said. For example, in one case, hospital employees showed a woman an X-ray of the crushed skull of a man they mistakenly thought was her husband. The woman sued the hospital for emotional distress and won at the trial stage. However, the appellate court said she was not entitled to recovery. "The law is not the guarantor for an emotionally peaceful life," the court wrote. ■

Suit alleges girl contracted HIV from vaccine

THEORY: Parents claim their daughter received a polio immunization tainted with simian immunodeficiency virus. BY TED HARTZELL

[CHICAGO] A suburban Chicago couple's lawsuit alleging that an oral polio vaccine caused their daughter's HIV infection is the first of its kind, according to John Cooney, the plaintiffs' attorney.

In *Williams vs. American Cyanamid Co.*, the plaintiffs claim that their infant daughter contracted HIV in 1982 from the three live-virus oral polio vaccinations she received, Cooney said. They are seeking more than \$10 million in damages. Cooney said the girl attends school and has "good months and bad months."

The suit, filed early this year in a federal court in New Jersey, alleges that Lederle Laboratories, a subsidiary of American Cyanamid, knew that its vaccine, Orimune, contained foreign viruses but that the company marketed it anyway, Cooney said. The case is based on theories of negligence, breach of implied warranty and strict liability for product defect, he said. In September, the Food and Drug Administration was named as

Law and Strategy, Kyle said Lederle extracted the vaccine lots from the kidneys of the African green monkeys, which is the only breed of monkey that harbors the virus and remains healthy.

Kyle claimed that the green monkeys used by Lederle showed no signs of illness because they could tolerate the SIV but that in humans who took the vaccine, the

SIV manifested as HIV. The U.S. Centers for Disease Control and Prevention and the FDA disputed Kyle's theory.

Kyle has maintained, however, that the vaccine batches released by Lederle through 1985 have tested positive for simian viruses, the article said. Citing his nearly 15 years of litigating polio vaccine cases, Kyle said his *Lancet* article was

based on thousands of documents obtained from Lederle during pretrial discovery motions, according to the Product Liability Law and Strategy article. Kyle, who has represented several people in suits against Lederle, said the company decided to market the vaccine even though it had evidence that the product might be tainted with HIV, the article noted.

In a public statement, American Cyanamid said, "There is absolutely no scientific basis for linking HIV virus or AIDS to the oral polio vaccine." The company said the case is "based on one of many unproven theories about the origin of AIDS." ■

The plaintiffs contend that their daughter's strain of the virus will more closely resemble simian immunodeficiency virus than HIV.

a defendant, because the FDA approved Orimune for worldwide distribution when it had reason to believe it was defective, Cooney claimed.

The allegations detailed in the lawsuit will be tested through two scientific processes, Cooney said. The first is a genome comparison of the girl's HIV and a control population. The plaintiffs contend that their daughter's strain of the virus will more closely resemble simian immunodeficiency virus than HIV. In making Orimune, Lederle extracted the basis for the vaccine from African green monkeys. The plaintiffs will try to show that the girl's body converted SIV into the deadly HIV.

Through the second process, more than 20 of the monopools of the three vaccine lots the girl received will be examined for the presence of retroviruses, said Cooney. He noted that all but two of the monopools still exist.

Internal company documents show that Lederle was aware that retroviruses were present when the vaccine was made, Cooney said. "We have experts in this case and laboratories that are dedicated to this cause."

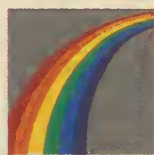
The suit relies heavily on the theories of a New Hampshire attorney, Walter S. Kyle, who in a 1992 *Lancet* article claimed he had linked certain Lederle polio vaccine lots with HIV, Cooney said. Kyle speculated that some of the lots contained HIV or similar viral agents that were unknown at the time. According to an article published last spring in *Leader's Product Liability*

In type I IDDM patients with retinopathy*

**NOW INDICATED
FOR DIABETIC NEPHROPATHY
(PROTEINURIA >500 MG/DAY)**



*The **only** drug therapy proven to slow the progression of diabetic kidney disease.*



CAPOTEN®
(captopril)

12.5 mg, 25 mg, 50 mg, 100 mg Scored Tablets

The recommended dosage of CAPOTEN for long-term use to treat diabetic nephropathy is 25 mg tid.

* Insulin-dependent diabetes mellitus.

CAPOTEN is contraindicated in patients who are hypersensitive to this product. Angioedema has been reported in patients receiving ACE inhibitors.

Please see brief summary on the adjacent pages.

USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, CAPOTEN should be discontinued as soon as possible. See **WARNINGS: Fetal/Neonatal Morbidity and Mortality.**

Solicitation

(Continued from page 8)

mation on how Weiss determined ISMIE's rating, and although several months have passed, that information hasn't been supplied."

According to Weiss spokesperson Greg Dubois, the company "looks at things from a very qualitative stance" to determine ratings. But the ISMIE spokesperson explained that Weiss uses only published financial data and puts them into a computer model, a process that does not allow for consideration of the variables underlying the numbers. Conversely, ratings issued

by A.M. Best and Standard & Poor's represent a total risk profile of a company because they consider qualitative and quantitative factors, the spokesperson said.

ISMIE received an NA-6 rating in 1993 from Best, because ISMIE is reinforced by several European and London-based companies that are not rated by Best. Even though Best's rating procedures cannot be applied to ISMIE, the company received positive comments in the 1993 edition of Best's Insurance Reports. According to that publication, ISMIE is the "largest writer of medical professional liability in the state of Illinois and ranks among the five largest

writers of professional liability in the United States." Best also cited ISMIE's "sound liquidity position."

As Illinois Medicine went to press, no action had yet been taken on the complaint ISMIE filed with the Department of Insurance. But regardless of any such action, ISMIE will move forward to "set the record straight and dispel the non-truths being circulated about the company," Dr. Jensen said.

ISMIE has been providing medical professional liability insurance in Illinois longer than any other company, and it is fiscally strong and secure, he continued. ISMIE has consistently received "solid

marks" on National Association of Insurance Commissioners tests designed to measure insurers' financial security, Dr. Jensen noted, adding that ISMIE also meets the strict regulatory standards of the Illinois Department of Insurance.

"Although ratings from reputable companies may be important, they don't provide a guarantee that an insurer will stay in the market," Dr. Jensen concluded. "Many other insurers have come and gone, but we've been meeting the needs of our policyholders for almost 19 years. As the state's Physician-First Service insurer, we will continue to keep ISMIE on sound financial footing." ■

CAPOTEN[®]

(captopril)

12.5 mg, 25 mg, 50 mg, 100 mg Scored Tablets

USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, CAPOTEN should be discontinued as soon as possible. See **WARNINGS: Fetal/Neonatal Morbidity and Mortality.**

CONTRAINDICATIONS: CAPOTEN (captopril) is contraindicated in patients who are hypersensitive to this product or any other angiotensin-converting enzyme inhibitor (e.g., a patient who has experienced angioedema during therapy with any other ACE inhibitor).

WARNINGS: Anaphylactoid and Possibly Related Reactions: Presumably because angiotensin-converting enzyme inhibitors affect the metabolism of eicosanoids and polypeptides, including endogenous bradykinin, patients receiving ACE inhibitors (including CAPOTEN) may be subject to a variety of adverse reactions, some of them serious. **Angioedema:** Angioedema involving the extremities, face, lips, mucous membranes, tongue, glottis or larynx has been seen in patients treated with ACE inhibitors, including captopril. If angioedema involves the tongue, glottis or larynx, airway obstruction may occur and be fatal. Emergency therapy, including but not necessarily limited to, subcutaneous administration of a 1:1000 solution of epinephrine should be promptly instituted. Swelling confined to the face, mucous membranes of the mouth, lips and extremities has usually resolved with discontinuation of captopril; some cases required medical therapy. (See **PRECAUTIONS: Information for Patients and ADVERSE REACTIONS.**) **Anaphylactoid reactions during desensitization:** Two patients undergoing desensitizing treatment with hymenoptera venom while receiving ACE inhibitors sustained life-threatening anaphylactoid reactions. In the same patients, these reactions were avoided when ACE inhibitors were temporarily withheld, but they reappeared upon inadvertent rechallenge. **Anaphylactoid reactions during membrane exposure:** Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes and treated concomitantly with an ACE inhibitor. Anaphylactoid reactions have also been reported in patients undergoing low-density lipoprotein apheresis with dextran sulfate absorption (a procedure dependent upon devices not approved in the United States).

Neutropenia/Agranulocytosis: Neutropenia (<1000/mm³) with myeloid hypoplasia has resulted from use of captopril. About half of the neutropenic patients developed systemic or oral cavity infections or other features of the syndrome of agranulocytosis. The risk of neutropenia is dependent on the clinical status of the patient:

In clinical trials in patients with hypertension who have normal renal function (serum creatinine less than 1.6 mg/dL and no collagen vascular disease), neutropenia has been seen in one patient out of over 8,600 exposed. In patients with some degree of renal failure (serum creatinine at least 1.6 mg/dL) but no collagen vascular disease, the risk in clinical trials was about 1 per 500. Doses were relatively high in these patients, particularly in view of their diminished renal function. In patients with collagen vascular diseases (e.g., systemic lupus erythematosus, scleroderma) and impaired renal function, neutropenia occurred in 3.7 percent of patients in clinical trials. While none of the over 750 patients in formal clinical trials of heart failure developed neutropenia, it has occurred during the subsequent clinical experience. Of the reported cases, about half had serum creatinine \geq 1.6 mg/dL and more than 75 percent received procainamide. In heart failure, it appears that the same risk factors for neutropenia are present.

Neutropenia has appeared usually within 3 months after starting therapy, associated with myeloid hypoplasia and frequently accompanied by erythroid hypoplasia and decreased numbers of megakaryocytes (e.g., hypoplastic bone marrow and pancytopenia); anemia and thrombocytopenia were sometimes seen. Neutrophils generally returned to normal in about 2 weeks after captopril was discontinued, and serious infections were limited to clinically complex patients. About 13 percent of the cases of neutropenia have ended fatally, but almost all fatalities were in patients with serious illness, having collagen vascular disease, renal failure, heart failure or immunosuppressant therapy, or a combination of these complicating factors. **Evaluation of the hypertensive or heart failure patient should always include assessment of renal function.** If captopril is used in patients with impaired renal function, white blood cell and differential counts should be evaluated prior to starting treatment and at approximately two-week intervals for about three months, then periodically. In patients with collagen vascular disease or who are exposed to other drugs known to affect the white cells or immune response, particularly when there is impaired renal function, captopril should be used only after an assessment of benefit and risk, and then with caution. All patients treated with captopril should be told to report any signs of infection (e.g.,

sore throat, fever). If infection is suspected, perform white cell counts without delay. Since discontinuation of captopril and other drugs has generally led to prompt return of the white count to normal, upon confirmation of neutropenia (neutrophil count < 1000/mm³) withdraw captopril and closely follow the patient's course. **Proteinuria:** Total urinary proteins > 1 g per day were seen in about 0.7 percent of patients on captopril. About 90% of affected patients had evidence of prior renal disease or received high doses (> 150 mg/day), or both. The nephrotic syndrome occurred in about one-fifth of proteinuric patients. In most cases, proteinuria subsided or cleared within 6 months whether or not captopril was continued. The BUN and creatinine were seldom altered in the proteinuric patients. **Hypotension:** Excessive hypotension was rarely seen in hypertensive patients but is a possible consequence of captopril use in salt/volume depleted persons (such as those treated vigorously with diuretics), patients with heart failure or those patients undergoing renal dialysis. (See **PRECAUTIONS: Drug Interactions.**) In heart failure, where the blood pressure was either normal or low, transient decreases in mean blood pressure > 20% were recorded in about half of the patients. This transient hypotension is more likely to occur after any of the first several doses and is usually well tolerated, although rarely it has been associated with arrhythmia or conduction defects. A starting dose of 6.25 or 12.5 mg tid may minimize the hypotensive effect. Patients should be followed closely for the first 2 weeks of treatment and whenever the dose of captopril and/or diuretic is increased. **BECAUSE OF THE POTENTIAL FALL IN BLOOD PRESSURE IN THESE PATIENTS, THERAPY SHOULD BE STARTED UNDER VERY CLOSE MEDICAL SUPERVISION.** **Fetal/Neonatal Morbidity and Mortality:** ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible. The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure. These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of captopril as soon as possible. Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment. If oligohydramnios is observed, captopril should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury. Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function. While captopril may be removed from the adult circulation by hemodialysis, there is inadequate data concerning the effectiveness of hemodialysis for removing it from the circulation of neonates or children. Peritoneal dialysis is not effective for removing captopril; there is no information concerning exchange transfusion for removing captopril from the general circulation. When captopril was given to rabbits at doses about 0.8 to 70 times (on a mg/kg basis) the maximum recommended human dose, low incidences of craniofacial malformations were seen. No teratogenic effects of captopril were seen in studies of pregnant rats and hamsters. On a mg/kg basis, the doses used were up to 150 times (in hamsters) and 625 times (in rats) the maximum recommended human dose. **Hepatic Failure:** Rarely, ACE inhibitors have been associated with a syndrome that starts with cholestatic jaundice and progresses to fulminant hepatic necrosis and (sometimes) death. The mechanism of this syndrome is not understood. Patients receiving ACE inhibitors who develop jaundice or marked elevations of hepatic enzymes should discontinue the ACE inhibitor and receive appropriate medical follow-up.

PRECAUTIONS: General: Impaired Renal Function — Hypertension — Some patients with renal disease, particularly those with severe renal artery stenosis, have developed increases in BUN and serum creatinine. It may be necessary to reduce captopril dosage and/or discontinue diuretic. For some of these patients, normalization of blood pressure and maintenance of adequate renal perfusion may not be possible. **Heart Failure** — About 20% of patients develop stable elevations of BUN and serum creatinine > 20% above normal or baseline upon long-term treatment. Less than 5% of patients, generally those with severe preexisting renal disease, required discontinuation of treatment due to progressively increasing creatinine. (See **DOSAGE AND ADMINISTRATION, ADVERSE REACTIONS: Altered Laboratory Findings.**) **Hyperkalemia:** Elevations in serum potassium have been observed in some patients treated with ACE inhibitors, including captopril. When treated with ACE inhibitors, patients at risk for the development of hyperkalemia include those with: renal insufficiency; diabetes mellitus; and those using concomitant potassium-sparing diuretics, potassium supplements or potassium-containing salt substitutes; or other drugs associated with increases in serum potassium. In a trial of type I diabetic patients with proteinuria, the incidence of withdrawal of treatment with captopril for hyperkalemia was 2% (4/207). In two trials of normotensive type I diabetic patients with microalbuminuria, no captopril group subjects had hyperkalemia (0/116). (See **PRECAUTIONS: Drug Interactions; ADVERSE REACTIONS: Altered Laboratory Findings.**) **Cough** — Presumably due to the inhibition of the degradation of endogenous bradykinin, persistent nonproductive cough has been reported with all ACE inhibitors, always resolving after discontinuation of therapy. ACE inhibitor-induced cough should be considered in the differential diagnosis of cough. **Valvular Stenosis** — A theoretical concern, for risk of decreased coronary perfusion, has been noted regarding vasodilator treatment in patients with aortic stenosis due to decreased afterload reduction. **Surgery/Anesthesia** — If hypotension occurs during surgery or anesthesia, and is considered due to the effects of captopril, it is correctable by volume expansion. **Hemodialysis:** Recent clinical observations have shown an association of hypersensitivity-like (anaphylactoid) reactions during hemodialysis with high-flux dialysis membranes (e.g., AN69) in patients receiving ACE inhibitors. In these patients, consideration should be given to using a different type of dialysis membrane or a different class of medication. (See **WARNINGS: Anaphylactoid reactions during membrane exposure.**) **Pregnancy:** Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible. **Drug Interactions: Hypotension** — Patients on Diuretic Therapy — Precipitous reduction of blood pressure may occasionally occur within the first hour after administration of the initial captopril dose in patients on diuretics, especially those recently placed on diuretics, and those on severe dietary salt restriction or dialysis. The possibility can be minimized by either discontinuing the diuretic or increasing the salt intake about one week prior to initiation of captopril therapy or by initiating therapy with small doses (6.25 or 12.5 mg). Alternatively, provide medical supervision for at least one hour after the initial dose. **Agents Having Vasodilator Activity** — In heart failure patients, vasodilators should be administered with caution. **Agents Causing Renin Release:** Captopril's effect will be augmented by antihypertensive agents that cause renin release. **Agents Affecting Sympathetic Activity** — The sympathetic nervous system may be especially important in supporting blood pressure in patients receiving captopril alone or with diuretics. Beta-adrenergic blocking drugs add some further antihypertensive effect to captopril, but the overall response is less than additive. Therefore, use agents affecting sympathetic activity (e.g., ganglionic blocking agents or adrenergic neuron blocking agents) with caution. **Agents Increasing Serum Potassium** — Give potassium-sparing diuretics or potassium supplements only for documented hypokalemia, and then with caution, since they may lead to a significant increase of serum potassium. Use potassium-containing salt substitutes with caution. **Inhibitors of Endogenous Prostaglandin Synthesis** — Indomethacin and other non-steroidal anti-inflammatory agents may reduce the antihypertensive effect of captopril, especially in low renin hypertension. **Lithium** — Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be coadministered with caution and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity. **Drug/Laboratory Test Interaction:** Captopril may cause a false-positive urine test for acetone. **Carcinogenesis, Mutagenesis and Impairment of Fertility:** Two-year studies with doses of 50 to 1350 mg/kg/day in mice and rats failed to show any evidence of carcinogenic potential. The high dose in these studies is 150 times the maximum recommended human dose of 450 mg, assuming a 50-kg subject. On a body-surface-area basis, the high doses for mice and rats are 13 and 26 times the maximum recommended human dose, respectively. Studies in rats have revealed no impairment of fertility.

Pregnancy Categories C (first trimester) and D (second and third trimesters). **See WARNINGS: Fetal/Neonatal Morbidity and Mortality.** **Nursing Mothers:** Concentrations of captopril in human milk are approximately one percent of those in maternal blood. Because of the potential for serious adverse reactions in nursing infants from captopril, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of CAPOTEN (captopril) to the mother. (See **PRECAUTIONS: Pediatric Use.**) **Pediatric Use:** Safety and effectiveness in children have not been established. There is limited experience reported in the literature with the use of captopril in the pediatric population; dosage, on a weight basis, was generally reported to be comparable to or less than that used in adults. Infants, especially newborns, may be more susceptible to the adverse hemodynamic effects of captopril. Excessive, prolonged and unpredictable decreases in blood pressure and associated complications, including oliguria and seizures, have been reported. CAPOTEN should be used in children only if other measures for controlling blood pressure have not been effective.

ADVERSE REACTIONS: Reported incidences are based on clinical trials involving approximately 7000 patients. **Renal:** About one of 100 patients developed proteinuria (see **WARNINGS**). Renal insufficiency, renal failure, nephrotic syndrome, polyuria, oliguria, and urinary frequency in 1 to 2 of 1000 patients. **Hematologic:** Neutropenia/agranulocytosis has occurred (see **WARNINGS**). Anemia, thrombocytopenia, and pancytopenia have been reported. **Dermatologic:** Rash, (usually maculopapular, rarely urticarial) often with pruritus, and sometimes with fever and eosinophilia, in about 4 to 7 of 100 patients (depend-

ing on renal status and dose), usually during the first four weeks of therapy. Pruritus, without rash, occurs in about 2 of 100 patients. A reversible associated pemphigoid-like lesion, and photosensitivity, have also been reported. Flushing or pallor has been reported in 2 to 5 of 1000 patients. **Cardiovascular:** Hypotension may occur; see **WARNINGS and PRECAUTIONS (Drug Interactions)** for discussion of hypotension with captopril therapy. Tachycardia, chest pain, and palpitations have each been observed in about 1 of 100 patients. Angina pectoris, myocardial infarction, Raynaud's syndrome, and congestive heart failure in 2 to 3 of 1000 patients. **Dysgeusia:** Approximately 2 to 4 (depending on renal status and dose) of 100 patients developed a diminution or loss of taste perception; taste impairment is reversible and usually self-limited even with continued drug use (2 to 3 months). **Angioedema:** Angioedema involving the extremities, face, lips, mucous membranes, tongue, glottis or larynx has been reported in approximately one in 1000 patients. Angioedema involving the upper airways has caused fatal airway obstruction. (See **WARNINGS: Angioedema.**) **Cough:** Cough has been reported in 0.5-2% of patients treated with captopril in clinical trials. (See **PRECAUTIONS: General, Cough.**) The following have been reported in about 0.5 to 2 percent of patients but did not appear at increased frequency compared to placebo or other treatments used in controlled trials: gastric irritation, abdominal pain, nausea, vomiting, diarrhea, anorexia, constipation, aphthous ulcers, peptic ulcer, dizziness, headache, malaise, fatigue, insomnia, dry mouth, dyspnea, alopecia, paresthesias. Other clinical adverse effects reported since the drug was marketed are listed below by body system. In this setting, an incidence or causal relationship cannot be accurately determined. **Body as a whole:** Anaphylactoid reactions (See **WARNINGS: Anaphylactoid and possibly related reactions and PRECAUTIONS: Hemodialysis.**) **General:** Asthenia, gynecostasia. **Cardiovascular:** Cardiac arrest, cerebrovascular accident/insufficiency, rhythm disturbances, orthostatic hypotension, syncope. **Dermatologic:** Bullous pemphigus, erythema multiforme (including Stevens-Johnson syndrome), exfoliative dermatitis. **Gastrointestinal:** Pancreatitis, glossitis, dyspepsia. **Hematologic:** Anemia, including aplastic and hemolytic. **Hepatobiliary:** Jaundice, hepatitis, including rare cases of necrosis, cholestasis. **Metabolic:** Symptomatic hyponatremia. **Musculoskeletal:** Myalgia, myasthenia. **Nervous/Psychiatric:** Ataxia, confusion, depression, nervousness, somnolence. **Respiratory:** Bronchospasm, eosinophilic pneumonitis, rhinitis. **Special Senses:** Blurred vision. **Urogenital:** Impotence. As with other ACE inhibitors, a syndrome has been reported which may include: fever, myalgia, arthralgia, interstitial nephritis, vasculitis, rash or other dermatologic manifestations, eosinophilia and an elevated ESR. **Fetal/Neonatal Morbidity and Mortality.** See **WARNINGS: Fetal/Neonatal Morbidity and Mortality.** **Altered Laboratory Findings: Serum Electrolytes: Hyperkalemia:** small increases in serum potassium, especially in patients with renal impairment (see **PRECAUTIONS**). **Hyponatremia:** particularly in patients receiving a low sodium diet or concomitant diuretics. **BUN/Serum Creatinine:** Transient elevations of BUN or serum creatinine especially in volume or salt depleted patients or those with renovascular hypertension may occur. Rapid reduction of longstanding or markedly elevated blood pressure can result in decreases in the glomerular filtration rate and, in turn, lead to increases in BUN or serum creatinine. **Hematologic:** A positive ANA has been reported. **Liver Function Tests:** Elevations of liver transaminases, alkaline phosphatase, and serum bilirubin have occurred.

OVERDOSAGE: Primary concern is correction of hypotension. Volume expansion with an I.V. infusion of normal saline is the treatment of choice for restoration of blood pressure. While captopril may be removed from the adult circulation by hemodialysis, there is inadequate data concerning the effectiveness of hemodialysis for removing it from the circulation of neonates or children. Peritoneal dialysis is not effective for removing captopril; there is no information concerning exchange transfusion for removing captopril from the general circulation.

DOSAGE AND ADMINISTRATION: CAPOTEN should be taken one hour before meals. In hypertension, CAPOTEN may be dosed bid or tid. Dosage must be individualized; see **DOSAGE AND ADMINISTRATION** section of package insert for detailed information regarding dosage in hypertension, heart failure, LVD after myocardial infarction and diabetic nephropathy. Because CAPOTEN is excreted primarily by the kidneys, dosage adjustments are recommended for patients with impaired renal function. (See **WARNINGS: Anaphylactoid reactions during membrane exposure and PRECAUTIONS: Hemodialysis.**) **[Consult package insert before prescribing CAPOTEN (captopril).]**

HOW SUPPLIED: Available in tablets of 12.5 mg in bottles of 100 and 1000; 25 mg in bottles of 100 and 1000; 50 mg in bottles of 100 and 1000; 100 mg in bottles of 100; and in Unimatic[®] unit-dose packs containing 100 tablets.

(J4-458F) 2/94



Bristol-Myers Squibb Company

IDPR DISCIPLINES

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

June 1994

Lyman B. Hollingsworth, Seattle – physician and surgeon license indefinitely suspended after being disciplined in the state of Washington.

Jonathan D. Slater, Bloomington – physician and surgeon license reprimanded upon issuance after being disciplined in the state of North Carolina.

Vaughn Tatum, Oak Park – physician and surgeon license placed on indefinite probation after allegedly failing to file certain state income tax returns.

July 1994

William F. Blank, Advance, MO – physician and surgeon license placed on indefinite probation; controlled substance license indefinitely suspended after being disciplined in the state of Missouri.

Ronald Chocola, Darien – physician and surgeon license and controlled substance license placed on probation for one year and fined \$2,000 after allegedly prescribing for nontherapeutic purposes.

Alfredo S. Dazo, Roseville, CA – physician and surgeon license placed on probation until June 2002 after violating a previous Department-ordered probation.

Dusan Gojkovich, Kankakee – physician and surgeon license reprimanded after billing for services not personally rendered to a patient.

Young Hwan Kim, Jacksonville – physician and surgeon license reprimanded after being disciplined in the state of Florida.

Keith Lasko, Fairview – physician and surgeon license indefinitely suspended after being disciplined in the state of California.

Olivio Leopando, Calumet City – physician and surgeon license reprimanded after prescribing class IV medications based on complaints of fatigue.

Mitchell Lee Levin, Ottawa – physician and surgeon license indefinitely suspended for a minimum of five years after being disciplined in the state of Florida.

William J. Mauer Jr., Arlington Heights – physician and surgeon license placed on indefinite probation after allegedly being delinquent on his individual tax liability due to the Illinois Department of Revenue.

Beryl McCann, Durant, OK – physician and surgeon license indefinitely suspended after being disciplined in the state of Oklahoma.

Rajani Patwari, Frankfurt – physician and surgeon license suspended for 30 days followed by probation for three years and 11 months; controlled substance license suspended for one year followed by probation for three years due to dishonorable, unethical and unprofessional conduct.

Michael Shapiro, Arlington Heights – physician and surgeon license reprimanded after failing to adequately safeguard triplicate prescription pads.

Special Announcement For Physicians Who Are PBT Plan Participants

You Have \$100,000 HIV Disability Program Coverage Free Of Charge!

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Simply Complete the coupon below and mail it along with a check for \$130 to the PBT at the address listed. Make check payable to: Physicians' Benefits Trust. If you have any questions or are not sure you participate in a PBT Plan, call our toll-free number to speak with one of our customer service representatives.

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You may enroll for up to an additional \$550,000 coverage, subject to a total coverage limitation of 5 times earnings. This additional amount is essential so that you have sufficient coverage for the the potential 5 years or more from the occurrence of HIV to the onset of total disability as defined by most Long Term Disability plans and Social Security. (For your privacy, we allow you to arrange the testing directly with an authorized local lab and then you are free to report the results to the PBT only after your review.)

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Yes! I am currently enrolled in a qualifying PBT Plan. Please enroll me for the PBT HIV Disability Program for an additional \$100,000 of coverage. My check for \$130 for the first year's premium is enclosed.



I am also interested in receiving information about enrolling for additional PBT HIV Disability Program coverage. I understand that I may purchase up to an additional \$550,000, subject to a total coverage limit of 5 times earnings. (The required testing will be performed at your expense.)

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List PBT Plan(s) you are enrolled in (See list above)

Practice Name:

Street:

Signature (Required): Date:

City/State/Zip:

Phone:



UNITED STATES POSTAL SERVICE Statement of Ownership, Management, and Circulation (Required by 39 U.S.C. 3685)

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PS Form 3526, October 1994 (Rev. 9/94)

FIRST OF TWO PARTS

Searching for clues in forensic medicine

*Physicians rely on science to reveal the identities
of crime victims and suspects.*

BY RICK ASA

For more than 20 years, eight victims of John Wayne Gacy have been unidentifiable. Their bodies, badly decomposed when unearthed under Gacy's home, had little to say, scientifically speaking.

But DNA testing, brought into the spotlight by the O.J. Simpson murder case, might offer some promise for those victims and their families, said Cook County Medical Examiner Edmund Donoghue Jr., MD, who worked the Gacy case as a forensic pathologist in the '70s.

Dr. Donoghue will try to have DNA extracted from the pulp of the remaining teeth of two Gacy victims and, if successful, check it against the DNA from blood samples provided by the families to identify similar characteristics. "They were elated to hear about [DNA testing], but I had to caution them that we have not extracted DNA from the teeth yet," he said. "It is a common procedure, but the question in this case is the age of the teeth and the fact that they were buried."

Still, DNA testing offers a means of possible identification that did not exist when the most heinous crime in Illinois history was discovered. For two siblings whose brother disappeared in 1972 and had no dental record, it is the best chance for identification.

An increasingly important medical tool in the fight against diseases, cancers and hereditary disorders in the last decade, DNA technology is now moving into the mainstream of forensic science. It can greatly narrow the range of probability that an alleged offender, such as Simpson, was at the scene of a violent crime.

"Violent crimes, especially those in which there is close physical contact between a victim and an offender, frequently involve an exchange of human cells," Dr. Donoghue said. "Hair, blood, semen or skin tissue from an offender may be left at the crime scene or on the victim, or the offender may be spattered by the victim's blood."

Few forensic pathologists do DNA profiling themselves, but they are responsible for the autopsies and

examinations that provide cell samples, along with other crucial characteristics of a violent crime. DNA testing for Dr. Donoghue's office – the only medical examiner's jurisdiction in Illinois – is done by the Illinois State Crime Lab in Springfield.

"Technology has improved to the extent that a good result can be obtained using small amounts of DNA material. Theoretically, a single cell is enough to provide the genetic material needed to do a DNA profile," he explained.

Previously, prosecutors in a largely circumstantial case like Simpson's would have had to rely on ABO blood-typing and blood-splatter evidence, which still help draw a complete picture of the crime but are not as helpful in identifying a particular suspect.

When Marian Caporusso began her career as a forensic scientist at the Chicago Police Department crime lab in the mid-1960s, ABO typing on a dried bloodstain "was the only thing that could be done," she said. Blood-typing results were simply contrasted with the percentage of the general population with the type of blood found to try to narrow the possibilities, said Caporusso, who is now the assistant director of the crime lab.

New enzyme systems came into their own by the late '70s, improving the odds to 1 in 10,000 "on a good case," Caporusso said. "The best case I ever had was a good typing on three- and four-year-old children who were sexually assaulted and killed. I testified it was 1 in 300,000. Now, DNA can come in [at] 1 in 300 million. It's phenomenal to see how the biological sciences have advanced the technology."

GENETIC PROFILING using DNA is highly accurate simply because there are so many possible DNA sequences. The chance of two people having identical genetic codes is "inconceivable," said Wayne Grody, MD, PhD, director of the DNA Diagnostic Laboratory at the UCLA School of Medicine. The chances of a match between two random samples are about 1 in 8 billion, a number larger than the world population, he noted.

At the pace DNA technology is moving now, it may only be a matter of time until the tests can provide virtually absolute identification, Caporusso said.

Although the Simpson case has highlighted the usefulness of DNA technology in violent crimes, DNA profiling has had its greatest impact in early diagnosis of diseases including HIV, tuberculosis, herpes and parasitic infections, said Karen Kaul, MD, PhD, director of the Molecular Diagnostic Laboratory at Evanston Hospital and assistant professor of pathology at Northwestern University.

Testing for tuberculosis at Evanston Hospital, although not common, has cut the definitive diagnosis for TB from two weeks or longer using lab cultures to about two days using a newer DNA profiling technique that amplifies even a small sample.

"I came out of a basic research background with a lot of molecular work," Dr. Kaul said. "Your typical physician with an MD is not trained to understand this, let alone do it. But there are more and more who do understand it. One of the things that I spend more of my time on is giving talks, trying to educate people on how this works and how it can help them manage their patients. There is still a steep learning curve in

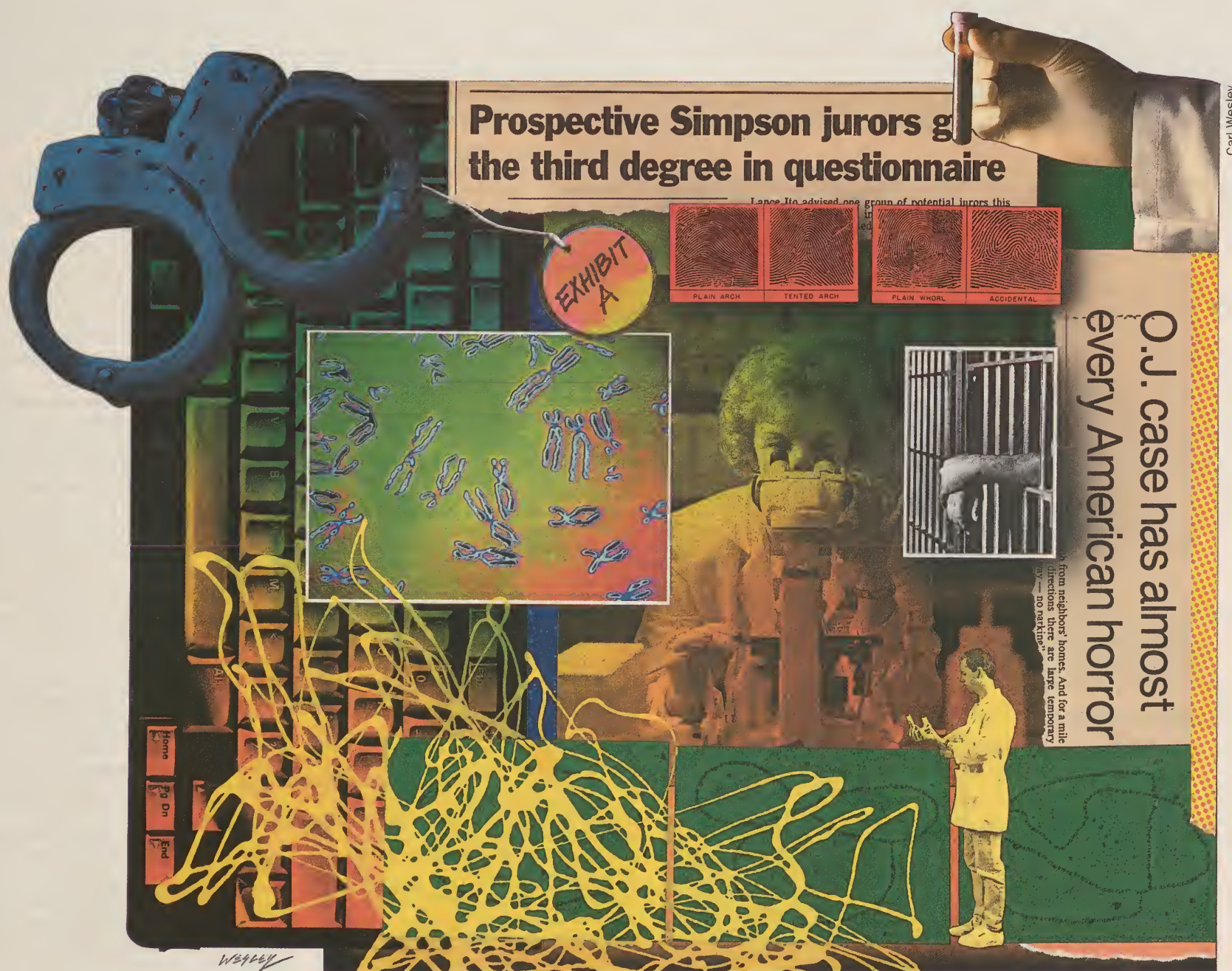
medicine. I've been working on this for the better part of a decade."

"Certainly any new technology in DNA is really first being developed for medical applications, and we are then taking that research to find DNA applications in forensics," said Susan Johns, research and development program administrator for the Illinois State Police Bureau of Forensic Sciences.

"There you have a natural link between forensic science and medicine," she said. "DNA has been used far longer in the medical community as a diagnostic tool. Gene therapy is already producing some spectacular advances. Much of this is useful when we look at our applications, and that tie certainly strengthens the dialogue between the medical community and the forensic science community."

Caporusso noted that DNA profiling was the first technology to move from the private sector, in contrast with most crime lab tests, which were developed in crime labs. "It's unique. The private sector gets involved from a profit motive, so at another point in time, if there is some revolutionary technology that is marketable, it will be transferred."

(Continued on page 14)



Carl Wesley

O.J. case has almost every American horror

from neighbors' homes. And for a mile in directions there are large temporary "no parking" signs.

DNA testing up close

BY RICK ASA

DNA testing was first used as admissible evidence in a test case in Great Britain in the early '80s, when English researcher Alec Jeffreys discovered DNA probes that improved the probability of genetic matching.

Using his newly discovered probes, Jeffreys conducted a test on a boy who was denied entry to the United Kingdom because immigration officials doubted his identity as the son of a Ghanian woman who was entitled to live in Great Britain. The test concluded that the boy was indeed the woman's son.

Profiling of a mother and child produces a high number of shared bands, or building blocks, since half the child's DNA genetic codes came from the mother and half from the father. Jeffreys' profile showed a high number of shared DNA bands between mother and son, with the chance of such a match occurring at random to be 30 million-to-1.

In the entire human code there are about 3 billion nucleotides, which are arranged in a specific sequence and look like bar codes. By probing a DNA sample with those various specific nucleotides, forensic scientists can narrow and identify traits such as those

found only in the same family.

The probe separates the DNA fragments, with many containing repeated sequences that occur throughout the chromosome. In purifying those repeated sequences and labeling them with radioactivity, forensic scientists can detect the patterns. The more DNA fragments identified by probing or the more radioactivity, the more exact an individual's DNA profile.

Each probe binds to a different area of a person's chromosomal DNA, so most crime labs use at least four probes, and sometimes as many as six, to better define the match. According to a report from the National Institute of Justice, use of multiple probes can identify an individual to a certainty of 1 in 1 million.

The most commonly tested samples are blood and semen, but even follicular cells of one strand of hair can be effective if newer amplification methods are used. Ideally, a freshly dried human biological sample will yield the most easily tested information, but a DNA profile has been obtained from samples more than 8 years old, and DNA testing has been successful on a 2,400-year-old Egyptian mummy, the NIJ said.

Of the two DNA profiling methods,

the dominant test in forensic science laboratories is restriction fragment length polymorphism analysis, said Marian Caporusso, assistant director of the Chicago Police Department crime lab. In that test, DNA is mixed with particular enzymes that cut the DNA into smaller fragments at specific genetically determined locations called "restriction sites." This creates varying lengths of DNA.

The DNA is then stimulated by an electrical charge, causing the DNA fragments to move in a gel medium. The movement, in turn, causes bands to form. The double-stranded DNA is separated into single strands by treating it with an alkali. Next, the DNA is transferred and washed with the radioactive probes for visualization of the bands and recording on X-ray film. The distinct bands can then be used to compare a suspect's DNA with DNA in samples found at a crime scene.

Multilocus probes, which can be used to identify more than one DNA segment at a time, are newer but more difficult to interpret and are typically not used in criminal cases, according to an August report by the American Society of Clinical Pathologists.

It is not unusual to have independent DNA analysis in the same case performed by more than one laboratory as a precaution, said Cook County Medical Examiner Edmund Donoghue Jr., MD.

One disadvantage of RFLP analysis is

that the process may take several weeks, depending on the number of single-locus probes used, said Karen Kaul, MD, PhD, director of the Molecular Diagnostic Laboratory at Evanston Hospital and an assistant professor of pathology at Northwestern University.

A significant amount of DNA is needed for readable results, and the DNA has to be purified or isolated from other cellular matter before the test is conducted, explained Dr. Kaul. To avoid damaging the DNA during analysis, careful handling is crucial, she added.

The second type of DNA analysis, polymerase chain reaction, can provide a path around those potential drawbacks by amplifying DNA through duplication of tiny pieces millions of times in the laboratory. The technique can be particularly useful in cases of slightly damaged DNA, because the technology duplicates only certain targeted DNA sequences and ignores the rest of the sample, Dr. Kaul said.

PCR is just beginning to be used in crime laboratories because it can be effective as a quick exclusionary tool, according to the ASCP report. But the likelihood of an accidental match is greater than with RFLP. The extreme caution required in criminal cases in which DNA profiling can be used as evidence requires that a positive PCR result be followed by a complete RFLP analysis. ■

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Forensic medicine

(Continued from page 13)

There is increasing public demand for DNA technology driven by news stories about DNA typing and what it can do, said Joseph Peterson, graduate program director and professor of criminal justice at the University of Illinois at Chicago. But he said he is skeptical that society really understands the need for scientific evidence in the criminal justice system. "The public takes a fairly simplistic view of crime and justice."

"[People believe] that more cops and more prisons are going to solve our problems, and that's not the case. Crime labs within police agencies over the years have gotten about 1 percent of the total budget. Most of the budget goes to visible patrol because that is politically what the community wants, and the lab is considered a good place to take kids on a field trip."

"Medical examiners, though, have been better funded and supported over the years," Peterson continued. "Because of their association with the medical community, in terms of standards, equipment and resources, they have been better off. An MD running an organization counts for something, and crime labs haven't had that prestige."

Johns sees opportunity for a closer relationship between forensic science, medicine and academia when a new state crime lab opens next year near the

UIC campus and the Cook County Medical Examiner's office. A groundbreaking ceremony for the new facility was held on Oct. 3. The Chicago Police Crime Lab, one of the first in the country and begun during the gangster heyday of the '20s, will close in 1996.

Informal discussions between the state lab and UIC criminal science faculty, for example, have begun a close working relationship, Johns said.

"I hope a forensic science program will be part of their academic program. We're hoping to see some research by the faculty on problems we need solved in the forensic sciences laboratory," she

continued. "I'm not sure [the College of Medicine] is where that would end up. We want a working relationship with academic scientists, whether that means pharmacology or pharmacodynamics or the medical side."

"My own feeling is that forensic science is trying very hard to make sure that our emphasis is on science, and when you do that,

you are going to see stronger ties with universities," Johns added.

Peterson said the criminal justice program there "is not well integrated with the medical side. We traditionally haven't had a lot of interaction, but I foresee that in the future we should. With the proximity of the new state lab, our program and the medical examiner's office, there should be greater integration." ■

*Any new technology
in DNA is really first
being developed for
medical applications,
and we are then taking
that research to find
DNA applications
in forensics.*

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OBITUARIES

*Indicates member of ISMS Fifty Year Club

*Albright

Arthur C. Albright, MD, a general practitioner from Chicago, died Aug. 5, 1994, at the age of 91. Dr. Albright was a 1937 graduate of the Meharry Medical College School of Medicine, Nashville, Tenn.

Block

George E. Block, MD, a general surgeon from Yorkville, died July 21, 1994, at the age of 67. Dr. Block was a 1951 graduate of the University of Michigan Medical School, Ann Arbor.

Flanagan

Charles L. Flanagan, MD, an internist from Lake Forest, died July 20, 1994, at the age of 68. Dr. Flanagan was a 1951 graduate of the Pritzker School of Medicine of the University of Chicago.

Flashner

Bruce A. Flashner, MD, a general surgeon from Highland Park, died July 25, 1994, at the age of 65. Dr. Flashner was a 1964 graduate of Northwestern University Medical School.

Gallagher

Dru Gallagher, MD, an anesthesiologist from Chicago, died Aug. 10, 1994, at the age of 40. Dr. Gallagher was a 1978 graduate of the Loyola University Stritch School of Medicine, Maywood.

Goldberg

Norma B. Goldberg, MD, a pulmonologist from Lake Forest, died Aug. 9, 1994, at the age of 63. Dr. Goldberg was a 1957 graduate of the Stanford University School of Medicine, Palo Alto, Calif.

Igini

John P. Igini, MD, a general surgeon from Oak Brook, died July 20, 1994, at the age of 70. Dr. Igini was a 1947 graduate of the Loyola University Stritch School of Medicine, Maywood.

Jones

Michael Jones, MD, a pathologist from Rock Island, died Aug. 31, 1994, at the age of 49. Dr. Jones was a 1975 graduate of the University of Iowa College of Medicine, Iowa City.

*Kwedar

Albert T. Kwedar, MD, an EM specialist from Springfield, died July 25, 1994, at the age of 83. Dr. Kwedar was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

*Murphy

Richard F. Murphy, MD, a general surgeon from Long Beach, Ind., died July 1, 1994, at the age of 80. Dr. Murphy was a 1939 graduate of the Loyola University Stritch School of Medicine, Maywood.

*Quinn

Charles S. Quinn, MD, a urologist from Rockford, died Aug. 16, 1994, at the age of 79. Dr. Quinn was a 1942 graduate of the University of Louisville School of Medicine, Kentucky.

*Snyder

Rufus A. Snyder, MD, a urologist from Decatur, died July 19, 1994, at the age of 82. Dr. Snyder was a 1936 graduate of the St. Louis University School of Medicine, Missouri.

*Turow

Irving L. Turow, MD, a psychiatrist from Peoria, died July 27, 1994, at the age of 84. Dr. Turow was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

ISMS 12th DISTRICT

Trustee William Kobler, MD (left), and Anthony Molinari, MD, an internist from Belvidere, discuss the status of health care reform last month at MedFest 94 in Lake Geneva. The three-day continuing medical education conference was sponsored by Saint Anthony Medical Center in Rockford.



Vince Pierri



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Edgar

(Continued from page 1)

think the biggest fear people have is the loss of their insurance coverage." He cited a bill he introduced in the General Assembly this year as a means to provide portable coverage for Illinoisans who lack insurance or who lose their insurance when they change jobs. The bill passed the Senate but was held in the House.

Referring to the financial challenges posed by Medicaid, Edgar said the states need flexibility to tailor health care reform to fit local needs. "The last thing we need is another federal program. We got burned on Medicaid several years ago, and I think we're all scared to death whenever Washington talks about us being [its] new partner on a new health care program. We end up being left holding the bag."

Tort reform, namely caps on noneconomic damages, is another health-related priority for the Edgar administration. The threat of lawsuits is increasing the practice of defensive medicine, which in turn is pushing health care costs higher, the governor said. "I'm hopeful [that through the general election] we'll see a change in the makeup of the General Assembly, which I think

gives us a lot better chance to see meaningful tort reform pass." If a bill capping noneconomic awards at \$250,000 does reach his desk, the governor said he will sign it.

We've got to send a very strong message to gangs that you're going to pay the price if you're going to operate in Illinois.

The state is in better fiscal condition today than it was four years ago when he took office, the governor said. Illinois' economy is one of the strongest of the 50 states, and its unemployment rate ranks among the lowest, he noted. However, the Medicaid program and its associated costs are still a "big question mark," Edgar said. "If we can see that [health costs for Medicaid] do not con-

tinue to increase as we've seen in the last few years, then I think we'll be in good shape."

The governor called Medicaid a "horrendous program" imposed on the state by the federal government. But Edgar said he is hopeful that the new Medicaid program, MediPlan Plus, which was approved by the General Assembly in July, will "allow us to see a slowdown in the increase in health care costs for the poor in the state and also allow us for the first time to at least try to redesign that program in a way that we can live with in Illinois."

The program, which is currently being reviewed by the U.S. Health Care Financing Administration, was prompted by Edgar during the spring legislative session. It adopts a managed care approach for the delivery of health care services to Medicaid recipients.

Under the program, health care experts, not government bureaucrats, will determine how best to use available funding to provide medical care to Medicaid patients, which should be more efficient, Edgar explained. "I think that's a lot better than just reimbursing people whenever they have some health problem. We end up paying for someone who has to be hospitalized for pneumonia when [the problem] could

have been treated earlier, when it was just a cold."

To combat crime in Illinois, Edgar said he advocates "getting tougher" on drug dealers, who are behind the "major movement of crime in our society today." In the spring session of the General Assembly, Edgar supported a series of legislative proposals aimed at cracking down on the illegal sale of firearms to children and giving police more authority to go after gangs. Those measures emerged from the Senate but were "held up in the House for political reasons," he said. "We've got to send a very strong message to gangs that you're going to pay the price if you're going to operate in Illinois. We also need to do a better job in prevention and early intervention in society. We need more involvement in the community to try to give kids an alternative to joining a gang."

Edgar said he is confident his record outshines that of his opponent, Illinois Comptroller Dawn Clark Netsch. "The best way to determine how someone acts after the election is [to look at] how they've acted in their office before. I think most physicians would feel much more comfortable with what we've done." ■

Netsch

(Continued from page 1)

said she has never supported such limits in medical liability cases. "First of all, I'm not prepared to say that for someone who has been effectively damaged because of medical negligence, \$250,000 is enough compensation. Secondly, there is virtually no evidence that malpractice claims have a significant effect on increasing health care costs."

In her campaign, Netsch has stressed that education must be a priority in Illinois. "Every year the budget battle is fought over education. By increasing the personal income tax from 3 percent to 4.25 percent, we'll have the necessary school funding, as well as be able to provide property tax relief. We can then take a more realistic approach to the budget, without having to resort to fiscal irresponsibility."

Although much attention has been focused on her proposal for a \$2.5-billion income tax increase, she has taken equally firm stands on health care issues that directly affect physicians. "As we have seen at the federal level, the reform of our health care system is a herculean task," she said. "Unfortunately, during the last few years we've done absolutely nothing in Illinois, in comparison to other states, when it comes to health care reform, such as initiating guaranteed accessibility and renewal. But we can implement some changes that will help people immediately. This includes shifting emphasis to preventative care, establishing regulatory oversight of insurance rates and making sure that all Illinois citizens have access to health care."

Given the shortage of primary care physicians in some rural and inner-city areas in Illinois, Netsch has proposed that current state subsidies for medical education be directed toward primary care physicians rather than specialists. "There are more than 40 counties in Illinois in which the availability of primary care doctors is scarce. During my cam-

paign Downstate, I was in one county in which women did not even have access to an Ob/Gyn. This can't be tolerated."

For physicians who treat trauma victims in emergency rooms, crime has become a pressing health problem.

No one, in good conscience, can believe that these guns should be permitted on our streets.

Netsch said she recognizes the impact of violent crime and Illinois voters' concern about the issue.

During her 18 years in the state Senate, Netsch supported gun control, and she remains steadfast in her support of a ban on semiautomatic assault weapons,

she said. "Banning these guns is a first and significant step in helping us fight crime. Law enforcement officials have seen a dramatic increase in the use of semiautomatic weapons, and recent statistics indicate that these guns are used in more than 10 percent of all gang shootings. No one, in good conscience, can believe that these guns should be permitted on our streets."

Besides a ban on semiautomatic weapons, another anti-crime initiative Netsch supports is the prevention of drug use and abuse. "Drugs are a major part of the crime syndrome. I would like to see additional education programs available. I also know that there are long waiting lists, sometimes as much as six months, for drug addicts to get into a treatment program. We have to speed this process up. Also, there is growing evidence that mandated anti-drug programs for those in prison help reduce recidivism. This is an area in which we can start making changes that will, in the end, help us combat crime."

During the campaign, Netsch has emphasized the need for an "honest bud-

get" to deal with the fiscal constraints facing Illinois, such as Medicaid. "For a long time, Illinois has lived well beyond its means. The result is that every year we're faced with some fiscal crisis, such as the current \$1.6-billion Medicaid debt that's had a terrible impact on doctors' practices, pharmacies and hospitals."

The recently signed Medicaid reform legislation, which calls for a managed care approach in the state's Medicaid system, is "too little too late" to make a substantive difference in keeping costs down, Netsch said. "Instead of establishing a pilot program to see how this program would work, we're plunging into a system in which there has been scant preparation for those on Medicaid. It's even hard to characterize this as a managed care program, given the number of options that are available - HMOs, PPOs, private insurance - as well as all the groups that are initially exempt from participating in this program. To put it mildly, this is a chaotic piece of legislation that is going to cause a great deal of frustration and confusion." ■

Attorney general

(Continued from page 1)

women and children. These programs can serve as a blueprint for change in the entire state."

Hofeld, who declined to be interviewed, has said in his television advertisements that he would use the post of Illinois attorney general to stem the growing epidemic of violence by and against children.

But he also recently said that the role of Illinois attorney general as a crime fighter has been overstated, according to a story in the St. Louis Post-Dispatch. "Anyone who contends that the attorney general should be the chief crime fighter in Illinois is going contrary to the constitution and laws of the state," he said.

Hofeld, who is a member of the Inner Circle of Advocates, a national organi-

zation of civil trial attorneys, has stressed in his campaign the need to fight for the "little guy" and tackle the pharmaceutical and insurance industries, as well as medicine. According to his campaign literature, he has won significant lawsuits against the medical establishment, pharmaceutical companies and nursing homes. If elected, he would establish a "health care strike force" to combat fraud and overbilling, the brochure said.

In his bid for the Democratic nomination for the U.S. Senate in 1992, Hofeld's campaign literature voiced the need for lower insurance costs and lower



Ryan

M. Candee Studios

costs for physician and hospital visits and prescription drugs. He said he also opposed denial of coverage by insurance companies based on age or disability. The brochure quoted the mother of a plaintiff in a medical malpractice case who said her daughter was "cheated out of her life by an uncaring doctor."

Ryan has also addressed tort reform, which he said is necessary to create an environment in Illinois that is conducive to the practice of medicine and business growth. "There is a great deal of lawsuit abuse, and the severity of some awards has gone out of control. I'm open to looking at a cap on noneconomic damage awards. The issue, however, is to come up with a solution that balances the rights of litigants while still retaining a pro-business climate." ■

Managed care

(Continued from page 1)

business office and nursing staff have to know which plans the practice has contracts with and the intricate details of each plan."

Failure to educate employees about the referral rules, co-pays, fee schedules and other policies that are unique to each plan could wreak havoc on practice profits, Wiskerchen warned. "If staff members don't understand referral rules, physicians could end up providing treatment for which they won't be reimbursed. It's also important to check the fee schedules and monitor the reimbursement the practice is receiving. Controls should be in place to catch discrepancies between what the contract says and what benefits are actually being received."

Zupko added that untrained office workers can cause problems for a medical practice. "If the receptionist enters data incorrectly, the practice's accounts receivable reports won't be accurate. For example, someone might put a Traveler's Network patient under Traveler's Indemnity or confuse Blue Cross Blue Shield HMO, PPO and traditional indemnity patients."

"Managed care plans are set up to disallow claims. It's the way they save money," said Carol Emmott, PhD, a partner with the executive recruiting and consulting firm SpencerStuart. "If the person responsible for patient accounts doesn't file a claim in the time a particular plan requires or doesn't include the appropriate documentation, the plan doesn't have to pay. And a physician's revenues can evaporate. I've heard a chorus of these kinds of complaints. For physicians, it's the worst form of 'Gotcha!'"

TO HELP office staff members deal with multiple insurers and efficiently manage patient accounts, all managed care information should be consolidated for easy access by all employees, Zupko and Wiskerchen advised. "We recommend compiling a comprehensive managed care file that contains the contracts, fee schedules, renewal dates and ID cards," Wiskerchen said. "In addition, we recommend creating a 'one-sheeter' that summarizes key points about each plan on one form that's available to all staff members at arm's length."

The consultants also stressed that to be effective, communication and training must be ongoing. "It can't be a one-time thing. You have to invest in training and keep your staff's skills current," Emmott explained.

"Physicians need a forum to share new and updated information with their staffs," Wiskerchen added. "Plans may make changes to referral panels or claims submission processes. I've yet to see a group not make changes throughout the year."

The beginning of the calendar year is a good time for physicians to review their managed care contracts with employees, since that's the "start time" for many plans, Wiskerchen recommended.

COMPUTERIZATION, too, is an important part of competent, cost-effective practice management, the consultants said. "If an office doesn't have at least some computer capability, it will be difficult to manage the information being generated," Wiskerchen said. Richard Ingram, president of Chicago-based

Integrated Health Care Solutions, agreed. "Practices have to start collecting patient information and sending claims electronically," he said, noting the availability of practice management software that facilitates calling up patient information like co-pays and eligibility on the spot. "But many physicians are reluctant to enter the computer age. I recently heard of one doctor who keeps his managed care contracts in cardboard boxes on his office floor."

Wiskerchen added that computerizing a practice proves worthwhile from financial and administrative perspectives. "It's very important to treat withholds [the risk reserves plans keep] as receivables

and not write them off when you receive payment. A computer can help physicians keep track of withholds and set up two codes: one a contract discount write-off, the other a withhold adjustment."

"Computerization is also important in tracking the number of patients in each managed care plan," she continued. "Physicians need a finger on that so that when contracts come up for renewal, they know where their patients are coming from. Physicians may find they participate in 50 plans with only 1 percent of their patients in each. That is administratively difficult."



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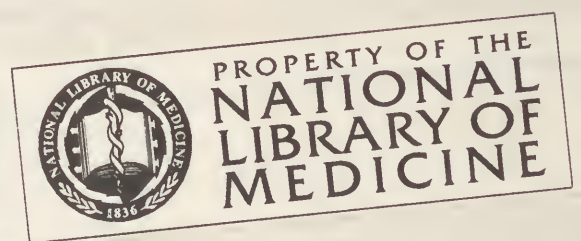
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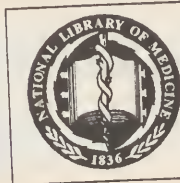
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Illinois Medicine

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Matt Ferguson

ISMS ALLIANCE President Carolyn Kobler (right) and Brenda Edgar watch as Gov. Jim Edgar signs a proclamation declaring October breast cancer awareness month. The Alliance was a sponsor of Mrs. Edgar's campaign to promote early cancer detection through mammograms and routine breast exams.

Chicago physicians are briefed on reform efforts

PROGRAM: Tort reform and ISMS services discussed at CMS branch meeting. BY KATHLEEN FURORE

[EVANSTON] Physician members of the Chicago Medical Society's North Suburban and North Shore branches received an update Oct. 12 about the future of health system reform. The program, part of ISMS' series of statewide member briefings, was presented by M. LeRoy Sprang, MD, ISMS secretary-treasurer and a Third District trustee. In addition to discussing health system reform, Dr. Sprang addressed ISMS advocacy efforts, the upcoming general election and new ISMS membership services. Holding up a copy of what he called the "horrendous Clinton

bill," Dr. Sprang said, "The window has closed on comprehensive health system reform this year. The single-payer plan and a rollback of medical malpractice reforms might be in store when the health care debate is reopened. That's why it is still very important that you know exactly what transpired in Washington this year and maintain contact with your elected officials. You need to offer yourselves as a resource to them when this issue rears its head in the 104th Congress." Dr. Sprang outlined the progress made by ISMS' Wash-
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INSIDE

Extra
service helps
small-town
hospital
succeed



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ISMS completes first phase of managed care evaluation

FEASIBILITY STUDY: The Society is exploring options to help physicians make the most of the changing environment. BY KATHLEEN FURORE

[CHICAGO] ISMS is moving into the second phase of its plan to add services designed to help members become proactive players in Illinois' growing managed care marketplace. Building on the information gathered to date, Society leaders will develop a business plan to test the recommendations from the results of the first-phase feasibility study conducted for ISMS by the consulting firm Health Direction Inc., of Redwood City, Calif., according to ISMS President Alan M. Roman, MD.

The study evaluated market trends and examined potential approaches ISMS could take to meet the needs of Illinois physicians, Dr. Roman said. "We recognize that the move into managed care is no doubt difficult, dramatic and even traumatic for physicians and patients who are used to a different model. We want to offer a whole new system of services to assist our members as they grapple with the unprecedented

changes occurring in the practice of medicine. We want to ease their transition into managed care and enable them to become leaders in a managed care environment."

To learn more about the Illinois health care market and determine physicians' needs, the study team interviewed ISMS leaders, representatives of third-party payers and employers throughout the state, Dr. Roman said. The study identified three main markets in Illinois, each with unique practice dynamics: Chicago and the collar counties, smaller metropolitan areas and nonmetropolitan, rural areas. Chicago-area hospitals are rushing to build integrated systems to meet the regional delivery requirements of big health plans, the study said. In small metro areas, two or three competing hospitals are typically discussing horizontal alliances among themselves or are developing physician-hospital organizations. And in
(Continued on page 14)

ISMS joins information network

COMPUTERS: Doctors and hospitals will be able to share patient information. BY JANICE ROSENBERG

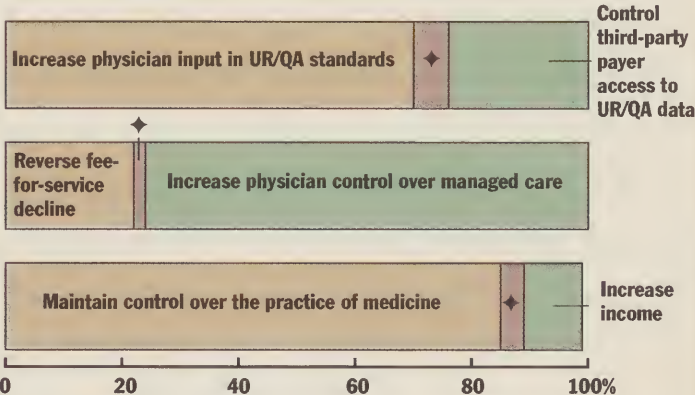
[CHICAGO] ISMS and the Metropolitan Chicago Healthcare Council are joining forces to form the nation's largest and most comprehensive community health information network. The two organizations will co-own and govern the Metro Chicago CHIN, making it the first network in the United States managed by a medical society and a hospital association.

"We are looking forward to working with ISMS in develop-

ing a network that will help us reduce the duplication of tests and treatment, speed diagnoses and increase efficiency," said MCHC President Earl Bird. "By joining with us in this venture, ISMS is making a major investment in meeting the health needs of the Chicagoland community and the millions of patients we serve."

CHINs are computer networks that allow all segments
(Continued on page 7)

In each set of options, which represents your preference about how ISMS should use its limited resources?



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Extra service helps small-town hospital succeed

RURAL MEDICINE: As other hospitals close, a husband and wife doctor team help keep health care in the community. BY ANNA CHAPMAN

[CLIFTON] The doors of 40-year-old Central Community Hospital in Clifton are still open, thanks to the dedication of its staff, said John Kuhn, the hospital's CEO. "It's a struggle, with scarce resources and problems with Medicare and Medicaid in Illinois." But even though some other small-town hospitals have failed, Central Community has succeeded with its five-member medical staff, he added.

"We like to pride ourselves on being a friendly community hospital and being a good neighbor," Kuhn said. The hospital serves the town of Clifton, which has 1,300 residents, as well as the 8,000 people who live in the surrounding communities. "Wherever we can improve service even a little bit, that's what we try to do."

"Our main emphasis is on our small but active medical staff led by Pat and Ted De Vas," Kuhn continued. G. Padhmini De Vas Gunawardhane, MD, a pediatrician, and her husband, A.T. De Vas Gunawardhane, MD, a general surgeon, have worked at the hospital for nearly 18 years. The husband and wife physician team from Sri Lanka form the "backbone of the hospital," Kuhn said.

Known to their patients as the Drs. De Vas, or more simply Dr. Pat and Dr. Ted,



Drs. Pat and Ted De Vas

the physicians provide family practice and general care to their patients in Clifton, as well as in satellite offices in the surrounding communities of Danforth, Gilman and Onarga.

The De Vases decided to practice in Clifton because they could work at the same hospital, Dr. Pat said. "There were no surgeons here, and I could do pediatrics. Being in a small town, we both do general practice. You have to do general practice or you won't survive."

"Dr. Pat is very dedicated," said Lois Miller, Dr. Pat De Vas' nurse and general office manager. "She's very caring and thorough." Miller noted that she and Dr. Pat work evenings at a clinic in Danforth

after Dr. Pat sees all her patients in Clifton. The clinic often stays open until midnight, she said. Some days, Dr. Pat leaves the Danforth office around 10:30 p.m. to work late into the night at the hospital. In addition, Dr. Pat has been known to pick up patients who are unable to drive and take them to the hospital.

"Older people who live far away have no way to get to the hospital," Dr. Pat said. "Of course I can put them in the car. It's not a big deal if there is no need to call an ambulance." Dr. Pat said she and her husband are available for patients 24 hours a day. "They call the hospital or us at home. It doesn't bother me to pick up the phone."

On her day off, Dr. Pat also serves as the medical director for the Nexus program, which operates live-in centers for troubled youth in Onarga and Manteno. In addition, she works in a Kankakee County clinic and an STD clinic every few weeks, she said. Dr. Ted also makes monthly rounds of three local nursing homes, seeing about 50 patients, Kuhn noted.

"I make friends with my patients," Dr. Pat said. "They have to be your friends or they won't communicate with you."

Cancer Information Center opens Downstate

[SWANSEA] Cancer patients, their family members and anyone interested in learning about the disease can now access up-to-date information at the new Cancer Information Center in Swansea. The center, which opened this summer in the main lobby of the town's Oncology Care Center, was created with the help of the American Cancer Society, Belleville Chapter, according to John Akscin, Oncology Care Center administrator.

"We saw a need in southern Illinois for a cancer resource center," Akscin said. "With the Cancer Information Center, we've condensed all the information into one central location and one program."

The volunteer-staffed center offers a wide array of information on all types of cancer, according to Akscin. Visitors can obtain brochures from the American Cancer Society and the National Cancer Institute, borrow books from a lending library, view videos in a private screening room on topics such as breast cancer and breast self-exams, and access the National Library of Medicine in Washington, D.C., through a direct computer link that places just-released information at their fingertips, he noted.

Early response to the new center has been encouraging, Akscin said. "Since we've centralized the information and let people know it's available, we've seen a significant increase in the information picked up by folks who need it."

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Physician's spouse vies for House seat

ISSUES: Republican Gwenn Klingler supports caps and licensing of UR agents. BY KATHLEEN FURORE

[SPRINGFIELD] When incumbent Rep. Michael Curran (D-Springfield) bowed out in August, the race for state representative in Illinois' 100th District turned into a battle between a physician's spouse and the Illinois State Bar Association's director of legislative affairs. That contest – between Republican Gwenn Klingler, a partner in general law at Boyle, Klingler and McClain and the wife of Springfield dermatologist W. Gerald Klingler, MD, and Democratic challenger Marylou Lowder Kent – will be decided in the Nov. 8 general election.

Klingler said her views on issues that affect physicians have helped distinguish her from her opponent. For example, Kent has lobbied against liability reform. "I think a cap of \$250,000 on totally subjective, noneconomic damages is essential to hold down costs," said Klingler, a member of the Sangamon County Medical Society Alliance. She has served as that group's legislative chairman and first worked with ISMS on its campaign to achieve tort reform in the mid-1980s.

"If we're honest about wanting to control costs, we have to control potential liability. That means we need to be able to predict the extent of liability exposure. Right now, the sky is the limit, and it's hard to set premiums. I think it's important for insurance companies to have a known amount for which they're insuring against risk. A cap will lead to better insurance predictability for physicians."

Klingler stressed, however, that limits should not be placed on awards for actual damages that might occur during treatment. "Patients who are injured should be fully compensated." She said she would also support legislation to require the loser in malpractice litigation to pay the winner's court costs and attorneys' fees, especially in suits that are "frivolous or found to be without merit."

Under Kent's legislative direction, the state bar association opposed tort reform proposed during the spring legislative session, according to the September 1994 issue of the Illinois Bar Journal. The bill, S.B. 1824, called for "omnibus tort reform changes involving punitive damages, noneconomic damages, comparative fault, collateral sources, products liability, joint liability, [the] Structural Work Act and wrongful death actions," the journal reported.

Utilization review is another issue of concern that must be addressed, since it is "one of the biggest areas of [potential] litigation," Klingler said. She advocates Illinois licensure of all physicians who conduct UR in the state and statutory liability for decisions that result in harm

to patients, she explained. "It is crucial that UR agents are held responsible for their decisions. Treating physicians are best able to decide what's best for the patient, and when a patient is harmed by a denial of care or different treatment [than is recommended by the treating physician], the responsibility must lie with the UR agency."

The Republican candidate said she opposes broadening the scope of practice

of allied health professionals. For example, she said she doesn't believe "nurse practitioners should be able to diagnose disease and prescribe medications."

Although this is Klingler's first bid for state office, it isn't her first brush with politics. In the early 1980s, she worked on a school board campaign for fellow Alliance member Jean Sherrick, the wife of retired Springfield radiologist Bill Sherrick, MD. Her interest piqued, Kling-

ler successfully campaigned for a spot on the Springfield District No. 86 School Board in 1987 and served as board president during the 1988-89 school year.

Klingler is the first and only female member of the Springfield City Council, serving as chairman of the Public Safety/Public Affairs Committee. To help curb teen alcohol abuse, she drafted and helped pass a city ordinance that calls for individuals to show proof of age when purchasing a keg of beer and requires stickers to be affixed to the keg so the buyer can be traced. Klingler said she is running for the House seat because she'd "like to work on these kinds of issues on a broader basis." ■



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REPORT *for Illinois Physicians*

ILLINOIS MEDICARE PART B

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- total cholesterol is under 200 mg/dL (5.2 mmol/L) and HDL cholesterol is under 35 mg/dL (0.9 mmol/L).
- total cholesterol is 200 to 239 mg/dL (5.2 to 6.2 mmol/L), and either HDL cholesterol is under 35 mg/dL (0.9 mmol/L) or two or more CHD risk factors are identified.
- total cholesterol is at or above 240 mg/dL (6.2 mmol/L).
- LDL cholesterol** has been 130 to 159 mg/dL (3.4 to 4.1 mmol/L), two or more CHD risk factors have been identified, and dietary therapy has been initiated, or dietary therapy and drug treatment are being rendered.
- LDL cholesterol has been at or above 160 mg/dL (4.1 mmol/L) and dietary therapy has been initiated, or dietary therapy and drug treatment are being rendered.

With evidence of coronary heart disease (CHD), if:

- LDL cholesterol is above 100 mg/dL (2.6 mmol/L) and dietary therapy, or dietary therapy and drug treatment are being rendered.

* Initial or screening determinations of total cholesterol, HDL cholesterol and triglycerides are *not* covered by Medicare.

** LDL cholesterol = (total cholesterol - HDL cholesterol) - (triglycerides/5). This calculation provides a reasonably accurate estimation of LDL cholesterol, unless triglycerides are at or above 400 mg/dL (4.5 mmol/L).

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EDITORIAL

Why you must vote

In past election years, you've heard all the reasons to vote. Maybe you've occasionally managed to rationalize them away. This election year, however, is a dangerous time for political ennui. We have too much at stake.

The congressional races are especially important because federal health care reform is still looming. President Clinton is expected to propose reform next year but in smaller chunks, according to recent media reports. Health and Human Services Secretary Donna Shalala said this year's bill was too difficult for the public to understand – too large a mouthful to swallow, apparently. But “if she's calling for piecemeal Clintonism, each bite will be indigestible,” said a spokesperson for House Republican Whip Newt Gingrich.

The Illinois House and Senate races are critical. Our state needs a \$250,000 cap on noneconomic damages in malpractice awards, and we need legislators who will support it. The momentum is with us. An ISMS survey of Illinois voters conducted last summer showed that 72 percent of respondents support caps on noneconomic damage awards because of the negative impact of litigation on overall health care costs. That result was corroborated by an Illinois Civil Justice League survey, which revealed that 90 percent of Illinois voters believe that lawsuits without merit are a serious problem.

To find out where a few candidates stand on caps and other important election issues, check out the “Election Quotables” box on the facing page. For a more comprehensive review of candidates in key congressional and State-house races, see the Sept. 23 and Oct. 7 issues of Illinois Medicine. Or you can call IMPAC at (312) 782-1963.

In addition to caps, there are other crucial state issues. Expanded scope of practice for allied health practitioners, public health initiatives and utilization review protections are just a few. If you read the legislative session coverage, you know how many health care-related bills are considered every year. We can't afford to leave decisions on those bills to chance. And who knows what new issues will surface as managed care proliferates? Illinois needs legislators who understand the complex implications of health policy. Such legislators are best qualified to be part of the decision-making and lawmaking processes.

If you think physicians can't make a difference, consider economic credentialing. Just this fall, Gov. Jim Edgar signed a bill making Illinois the first state to pass legislation protecting physicians from economic credentialing by hospitals. The desire for due process that began at ISMS' 1993 House of Delegates meeting is now a reality.

We've made great headway in educating the public about the need for caps. Don't skip the next step. Vote!

PRESIDENT'S LETTER

Membership begins with me

Alan M. Roman, MD



While many of you were busy with your practices, your Society was busy representing you.

It is a privilege and pleasure for me to foster discussion on health care issues. This evokes frequent letters from members, including one that has become my favorite: “I have felt very proud to be associated with you and have had my faith restored in my profession as being composed of the true cream of society, although we may not be monetarily rewarded as such. But pride in yourself is worth much more than money, and I have never been ashamed to say in any company, ‘I am a doctor.’”

I have been privileged to crisscross the state on the President's Tour speaking to the public. Your Society responds daily to multiple requests from outside organizations for medicine's perspectives on a variety of issues. Each is given careful attention. I've reached thousands of members through presentations to county societies and written communication such as this letter. These activities help meet the Society's mission of promoting the art of medicine, elevating medicine's standards and protecting the public's health.

Your Society serves as your advocate in hundreds of legislative initiatives affecting all physicians. ISMS promoted your views on health system reform to the Illinois congressional delegation. And we were instrumental in the passage of the first state law in the nation achieving due process protections against economic credentialing. While many of you were busy with your practices, your Society was busy representing you. You may not pay for all you get, but you certainly get all you pay for.

As your advocate for medical malpractice reform, we are working to elect individuals sympathetic to medicine's viewpoint, and we look forward to achieving a limit on noneconomic damage awards.

Through member briefings, we've asked you questions about yourselves and your needs, and we've listened to understand where you are. We recognize that life is a continuous process of adjusting to the unanticipated, and we realize your survival and ours is predi-

cated on your ability to deal with those changes. Your Society has taken no position on the merits of fee-for-service medicine vs. managed care, but in these changing times, we cannot ignore the marketplace dynamics. We therefore want to provide you with as many services as we can. Most of all, we are trying to increase physician participation so that physicians can become the leaders and standard-setters in this new medical environment.

In my early years of practice, I wanted to be a member of organized medicine. Now, more than ever, I need to be a member. It is unfortunate that the only bond shared by members and nonmembers is the Hippocratic Oath. Never has there been a stronger need for a unified voice and for all physicians to belong to organized medicine.

I frequently receive letters or calls from nonmembers asking for the Society's help, and they make me very uncomfortable. Nonmembers receive the benefits without paying the dues, and that costs all of us. Advocacy by your Society benefits all physicians.

With health system reform, the timing for outreach to nonmembers has never been better. There are not only the obvious benefits but the intangibles as well – the support and guidance provided by your Society. Think of the potential common interests, the credibility and the political purposes to be gained when physicians come together through organized medicine.

Regardless of how physicians choose to organize or deliver care, one constant will be your Society. Each and every physician must consider the future to be his or her responsibility. We must find the courage to move forward, despite risk, and to commit the time necessary to stay close to the leading edge.

We need search no harder for a reason to belong than because it's the right thing to do. I, too, am proud to say that I am a physician. And I know that membership begins with me.

Election Quotables

"I don't think anybody would argue the fact that there are some frivolous lawsuits, and we ought to try to find ways to prevent [them] from happening."

— **Jim Ryan**, Republican attorney general candidate, CLTV

"As far as caps on damages, I think the insurance companies basically are putting out that kind of propaganda, and I don't think it would serve the victims very well at all."

— **Al Hofeld**, Democratic attorney general candidate and plaintiff lawyer, CLTV

"The American Medical Association says over 53,000 doctors got sued for malpractice last year. I asked the American Bar Association how many lawyers got sued for malpractice, and do you know what they told me? They said they don't keep track."

— **Andy Rooney**, "60 Minutes"

"I'm hopeful we'll see a change in the makeup of the General Assembly, which I think gives us a lot better chance to see meaningful tort reform pass."

— **Jim Edgar**, Republican incumbent gubernatorial candidate, Illinois Medicine

"I'm not prepared to say that for someone who has been effectively damaged because of medical negligence, \$250,000 is enough compensation. There is virtually no evidence that malpractice claims have a significant effect on increasing health care costs."

— **Dawn Clark Netsch**, Democratic gubernatorial challenger, Illinois Medicine

"Crime is a big problem with a straightforward solution — punish the criminals who plague our streets."

— **Kathy Parker**, 29th District (north suburban Chicago) Republican candidate, campaign literature

"I would have voted 'no' on this if not for the election year. I keep hearing this is a law-and-order year."

— **Sen. Grace Mary Stern**, Democratic incumbent in the 29th District (north suburban Chicago), explaining her 'present' vote on a crime bill, St. Louis Post-Dispatch

"It is crucial that UR agents are held responsible for their decisions. Treating physicians are best able to decide what's best for the patient."

— **Gwenn Klingler**, 100th District (Springfield) Republican candidate, Illinois Medicine

"Marylou Lowder Kent now hopes to put to use as an Illinois legislator the expertise she has gained as Illinois State Bar Association director of legislative affairs."

— **The Illinois State Bar Association's Bar News**, describing the Democratic candidate in the 100th District (Springfield) race

"We need strong medical malpractice reform, including a \$250,000 cap on noneconomic damages."

— **Ray LaHood**, 18th Congressional District (Peoria and surrounding areas) Republican candidate, news conference

"I have tried desperately not to call myself Judy Garland Topinka."

— **Sen. Judy Baar Topinka**, Republican candidate for state treasurer, on the name of her opponent, Nancy Drew Sheehan, Chicago Tribune



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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

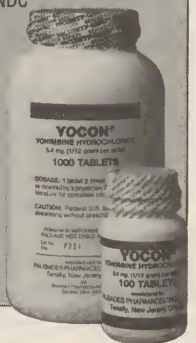
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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LETTERS

A legal distinction

I read Illinois Medicine every two weeks with great interest. The Aug. 26 issue caused me some concern. The editorial was titled "Trial lawyers move to undermine tort reforms." A guest editorial was titled "Latest winners of health fight: trial lawyers."

I understand that these references are to the various organizations of the plaintiff's bar that choose to call themselves trial lawyers.

I am not certain that your readers understand the connotations. We who defend you are trial lawyers. We try cases in your behalf every day and usually win. There is nothing wrong with being a trial lawyer. In fact, most of us are very proud of spending our lives defending health

care professionals.

Maybe in the future it might be wise when you are attacking trial lawyers for you to distinguish those trial lawyers who defend your interests from those who oppose them.

We who defend you are not litigators; we are trial lawyers.

— **Richard G. French**
French Kezelis & Kominarek
Chicago

Editor's note: The editorials cited did indeed refer to the Association of Trial Lawyers of America and its members, not to all trial lawyers. We regret any misunderstanding.

Illinois Medicine reserves the right to edit all letters for publication.

Tort reform discussed at ISMS member briefing

PAGE 1

ISMIE Update

'Election Quotables' highlights candidates' positions on caps in key races

PAGE 5

Panel addresses litigation costs

PROGRAM: A physician, a plaintiff attorney and a drug company executive express divergent views on the impact of liability lawsuits. BY MINDY KOLOF

[OAK BROOK] The topic of a September panel discussion on ethics was the emotional, physical and financial costs of increasing medical malpractice suits. The program was part of a daylong conference sponsored by the DuPage County Medical Society.

The sharp rise in liability costs is affecting overall health care costs, said panelist Patricia Merwick, MD, an Elmhurst internist and past president of the DuPage County Medical Society. In 1988, direct costs—including medical malpractice premiums and legal fees to defend claims—totaled \$9.6 billion, and \$20 billion was spent on the practice of defensive medicine, she said.

The current legal system fails to achieve its objectives, Dr. Merwick said. "It's very cumbersome, expensive and highly inefficient, and doesn't address the perceived goal of giving the rightfully injured party full recompense."

Panel moderator Robert Clif-

ford, a plaintiff attorney and partner in the Chicago firm of Corboy, Demetrio, Clifford, said malpractice premiums account for less than 5 percent of a physician's overhead costs. He added that although jury awards for malpractice appear very high, "in the majority of cases where the total exceeds the physician's malpractice policy limits, they are settled within the dollar limits of their policy."

Clifford claimed that achieving universal access to health care through reform would "probably have an impact on jury verdict amounts" because the cash value of future care would be less. He said he opposes limits on jury awards. "Show us a way to resolve this we can all afford. But don't place caps."

The establishment of practice guidelines by groups of physi-

cians would help stem malpractice-related costs, Dr. Merwick said. "In Maine, specialists got together and set guidelines they all agreed on. The legislature has made those standards an affirmative defense in a malpractice suit, which may be raised at the discretion of the defendant."



Dr. Merwick

John McNulty

THE COSTS associated with malpractice suits affect physicians on several levels, Dr. Merwick said. In addition to incurring insurance-related expenses, physicians facing claims lose time from their practice when they give depositions and attend trials, she said. To try to avoid malpractice suits, physicians have focused heavily on documentation, which has resulted in additional computer, charting and labor costs, Dr. Merwick noted. "Not only does it impede my ability to get to the nuts and the bolts of the issue, but it takes away from the time the nurses could be caring for patients."

Although the costs stemming

from litigation are considerable, physicians must also deal with the emotional aspects of being sued, Dr. Merwick said. "The doctor-patient relationship is a personal one, and a lawsuit, rightly or wrongly brought, has significant emotional impact on the physician's well-being. Symptoms range from headaches and gastrointestinal illness to mental disturbance, major depression and even suicide."

The time it takes to resolve lawsuits adds to the distress, Dr. Merwick continued, noting that some cases drag on for as long as four years. Many doctors retire afterward, regardless

of whether they were found negligent, she said. "Can we afford the loss of well-trained physicians, who may otherwise have been in the prime of their career, because of the enormous personal cost to them?"

Those physicians who don't leave the profession after being sued frequently change their practice patterns, Dr. Merwick explained. They limit their hours, refuse to see particular types of patients and abandon specialties that are perceived to be high risk, she said. "Overall, this reduces the availability of care."

PRODUCT LIABILITY lawsuits are also driving up costs, Dr. Merwick said. For example, the price of conducting clinical trials for new drugs is rising, said panel member Frank Douglas, executive vice president of research and development for Marion Merrell Dow Inc. "If extensive studies are required, a pharmaceutical company might decide not to pursue a new drug because [it] couldn't charge enough to offset the costs."

A balance must be struck between upholding scientific standards for testing and assuring that individuals have access to therapies for life-threatening illness or have redress if the therapy goes awry, he said.

The expansion of managed care, with its emphasis on cost containment, poses new liability concerns for physicians, Dr. Merwick said. "Since there is an incentive for providers to limit care, some type of ethic and corresponding legal accountability should be inherent in the system itself."

MALPRACTICE ROUNDUP

Courts are changing views on third-party examinations

Courts nationwide are handling more medical malpractice claims involving nontraditional physician-patient relationships, according to an article in Medical Malpractice Law & Strategy. Such relationships can be created when a physician examines a patient on behalf of an employer or an insurer, or for litigation purposes, the article stated.

Although courts have ruled differently in such cases, a trend is emerging in how physician-patient relationships involving a third party are viewed: a shift away from governance under contract law and toward governance under tort law, the article said.

Until recently, a cause of action by a plaintiff against a physician in such cases was based on the premise that a contract for medical services existed between the physician and patient. But breach of the so-called contract has evolved into the principle of breach of duty to treat each patient with reasonable care, according to the report.

The application of tort law in those cases means a patient could be a regular consumer of the physician's services or just a one-time referral. The shift has also allowed courts to create liability for physicians that is based on a general duty to practice

within a professional standard of care, the article stated.

As an example of this expanded view of a physician's duty to the patient, the article cited a case in which a doctor examined a patient and took chest and spinal X-rays during an annual examination required by the patient's employer. The physician reported that the patient was "employable without restriction" and that all test results were normal. A year later, the patient was diagnosed with lung cancer and subsequently died from the disease. The patient's estate sued, alleging that the physician should have detected the cancer during the exam.

A U.S. appeals court held that the exam had created a duty on the part of the physician not only to interpret the results within the standard of care but also to do what was reasonable to inform the patient in a timely manner of any findings indicating an imminent danger, the article said.

However, other courts have interpreted the occasional physician-patient connection differently. For instance, a New York court focused on the intent and scope of that relationship when it ruled that a physician who had examined an employee at the company's request could not be held liable for failing to detect a latent brain stem tumor. According to the article, the court said the physician had never offered or intended to treat or care for the patient and had no reason to believe the man would rely on his report.

Information network

(Continued from page 1)

of the health care industry to communicate with one another. They use integrated computers to form electronic links between hospitals, physicians, payers, employers, laboratories, pharmacies and other parties, which permit a rapid exchange of clinical and financial information.

Currently, about 100 such networks are in some stage of development throughout the country, the council said. The council, which originated the network, is a membership and service organization representing 100 local hospitals and health care organizations.

Network participants reap several benefits, including the ability to admit patients to hospitals, order tests, receive test results and status reports, exchange patient-specific clinical information, transmit claims and payments and transfer funds, an ISMS analyst said. CHINs are intended to reduce health care system costs by reducing paperwork and administrative inconveniences and easing communication among health care providers.

As the CHIN's primary users, physicians should certainly take a role of leadership in its development, to assure it provides substantial benefits.

After implementation, physicians will be able to communicate clinical and other information with one another through the CHIN. The network will enable doctors to obtain laboratory results more quickly and track patients and their medical conditions over time, the analyst noted.

Ideally, once claims are processed by an insurer, an explanation of benefits could be sent back to physicians over the network, and funds could be electronically transferred from the insurance company's bank account to the hospital's or the physician's bank account. CHIN data are never stored in midpoint data banks of any kind, and there is no opportunity for "hackers" to break into a centralized data base, the analyst said.

"The CHIN has vast, exciting potential to improve patient care," said ISMS President Alan M. Roman, MD. "At the same time, it can help contain costs by reducing administrative hassles and cutting paperwork. As the CHIN's primary users, physicians should certainly take a role of leadership in its development, to assure it provides substantial benefits. ISMS is aware of the potential confidentiality problems that can exist with a comprehensive data base and will work to ensure that the information in the network is not compromised and is kept strictly confidential."

The CHIN should also help physicians

with risk management by providing practice information, said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. "The CHIN data will give physicians a picture of their practice pattern, trends and areas on which they need to focus attention. In turn, this information will help them determine their educational and risk management needs."

The agreement between ISMS and the council, which was ratified by the ISMS Board of Trustees in September, specifies that the Metro Chicago CHIN will function as a not-for-profit entity. The two groups will each hold a 50-percent own-

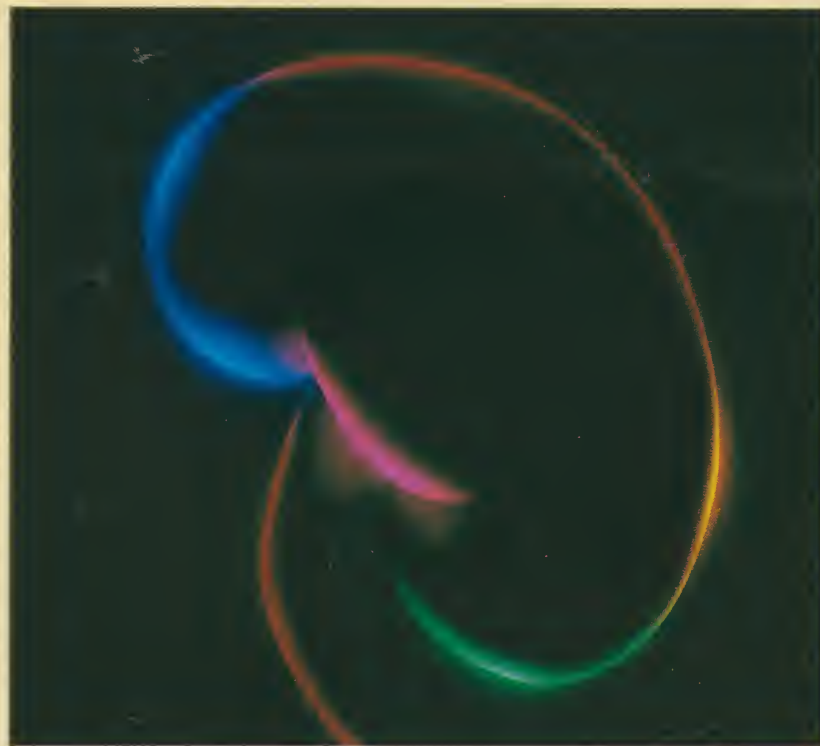
ership in the network and will work together to implement it, according to the MCHC. The network will be governed by a 20-member board of directors. Seven board members will be appointed by ISMS, seven by the council, and six, chosen by the two groups jointly, will represent the business and payer communities.

The CHIN board will decide policy issues such as how to charge for use of the network, which functions should become operational first and when to bring individual hospitals and providers on-line. Board members will also address security and confidentiality issues.

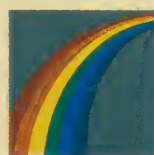
The board will select a vendor to operate the network, and development of the system's infrastructure should begin soon afterward. The board anticipates that six to 12 hospitals will be connected to the network in its first year, according to the ISMS analyst. Therefore with 100 potential institutional members in the area, it may take several years for the network to cover them all. Physicians who want to participate in the network must have a computer and a modem. Information about how to join the network will be available following vendor selection. ■

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Please see brief summary on the adjacent pages.

USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, CAPOTEN should be discontinued as soon as possible. See WARNINGS: Fetal/Neonatal Morbidity and Mortality.

Member briefings

(Continued from page 1)

ington Presence program. "Our objective this year was to persuade as many members of the Illinois congressional delegation as possible to vote for a health system reform plan acceptable to Illinois physicians." Throughout the congressional session, ISMS leadership met with Illinois' representatives and senators, encouraging them to support proposed federal legislation calling for modest antitrust relief for physicians through the creation of safe harbors for some cooperative activities. The Society also pushed for the enactment of a \$250,000 cap on

noneconomic damages, he said.

Physicians should become involved in ISMS' grass-roots efforts, he said. "Health reform is not a spectator sport. Offer [your legislators] personal experiences, ask for what you want, tell them what your patients need. And urge your patients to do the same. We have yet another chance to help formulate a national health plan that offers meaningful, comprehensive system reform without compromising ourselves



Dr. Sprang

John McNulty

or our patients."

Emphasizing the need for significant tort reform, Dr. Sprang noted that the number of claims filed against ISMIE policyholders has more than doubled since 1986 and that the average award in an ISMIE case closed with indemnity was \$350,000 in 1993. "Increasing awards have fostered a lottery mentality that has driven up the frequency of claims against physicians. And though the vast majority of these claims are unfounded, they are extremely costly to defend."

Last year, ISMIE paid more than \$51 million in legal costs and other expenses to defend physicians involved in malpractice claims, even though most claims

were unfounded and ultimately closed with no payment to the plaintiff, he said.

Dr. Sprang also described ISMS' efforts to help physicians cope with the changes in Illinois' medical marketplace. Two new services are a toll-free action line — (800) MD-ASIST — and the ISMS Lawyer Referral Network. A consultant referral service will debut soon, he said.

Dr. Sprang stressed that ISMS is committed to creating a roster of new services to help physicians maintain a position of strength in dealing with managed care and health system reform. "ISMS stands ready to help you manage those challenges." ■

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USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, CAPOTEN should be discontinued as soon as possible. See WARNINGS: Fetal/Neonatal Morbidity and Mortality.

CONTRAINDICATIONS: CAPOTEN (captopril) is contraindicated in patients who are hypersensitive to this product or any other angiotensin-converting enzyme inhibitor (e.g., a patient who has experienced angioedema during therapy with any other ACE inhibitor).

WARNINGS: Anaphylactoid and Possibly Related Reactions: Presumably because angiotensin-converting enzyme inhibitors affect the metabolism of eicosanoids and polypeptides, including endogenous bradykinin, patients receiving ACE inhibitors (including CAPOTEN) may be subject to a variety of adverse reactions, some of them serious. **Angioedema:** Angioedema involving the extremities, face, lips, mucous membranes, tongue, glottis or larynx has been seen in patients treated with ACE inhibitors, including captopril. If angioedema involves the tongue, glottis or larynx, airway obstruction may occur and be fatal. Emergency therapy, including but not necessarily limited to, subcutaneous administration of a 1:1000 solution of epinephrine should be promptly instituted. Swelling confined to the face, mucous membranes of the mouth, lips and extremities has usually resolved with discontinuation of captopril; some cases required medical therapy. (See PRECAUTIONS: Information for Patients and ADVERSE REACTIONS.) **Anaphylactoid reactions during desensitization:** Two patients undergoing desensitizing treatment with hymenoptera venom while receiving ACE inhibitors sustained life-threatening anaphylactoid reactions. In the same patients, these reactions were avoided when ACE inhibitors were temporarily withheld, but they reappeared upon inadvertent rechallenge. **Anaphylactoid reactions during membrane exposure:** Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes and treated concomitantly with an ACE inhibitor. Anaphylactoid reactions have also been reported in patients undergoing low-density lipoprotein apheresis with dextran sulfate absorption (a procedure dependent upon devices not approved in the United States).

Neutropenia/Agranulocytosis: Neutropenia ($<1000/\text{mm}^3$) with myeloid hypoplasia has resulted from use of captopril. About half of the neutropenic patients developed systemic or oral cavity infections or other features of the syndrome of agranulocytosis. The risk of neutropenia is dependent on the clinical status of the patient:

In clinical trials in patients with hypertension who have normal renal function (serum creatinine less than 1.6 mg/dL and no collagen vascular disease), neutropenia has been seen in one patient out of over 8,600 exposed. In patients with some degree of renal failure (serum creatinine at least 1.6 mg/dL) but no collagen vascular disease, the risk in clinical trials was about 1 per 500. Doses were relatively high in these patients, particularly in view of their diminished renal function. In patients with collagen vascular diseases (e.g., systemic lupus erythematosus, scleroderma) and impaired renal function, neutropenia occurred in 3.7 percent of patients in clinical trials. While none of the over 750 patients in formal clinical trials of heart failure developed neutropenia, it has occurred during the subsequent clinical experience. Of the reported cases, about half had serum creatinine ≥ 1.6 mg/dL and more than 75 percent received procainamide. In heart failure, it appears that the same risk factors for neutropenia are present.

Neutropenia has appeared usually within 3 months after starting therapy, associated with myeloid hypoplasia and frequently accompanied by erythroid hypoplasia and decreased numbers of megakaryocytes (e.g., hypoplastic bone marrow and pancytopenia); anemia and thrombocytopenia were sometimes seen. Neutrophils generally returned to normal in about 2 weeks after captopril was discontinued, and serious infections were limited to clinically complex patients. About 13 percent of the cases of neutropenia have ended fatally, but almost all fatalities were in patients with serious illness, having collagen vascular disease, renal failure, heart failure or immunosuppressant therapy, or a combination of these complicating factors. **Evaluation of the hypertensive or heart failure patient should always include assessment of renal function.** If captopril is used in patients with impaired renal function, white blood cell and differential counts should be evaluated prior to starting treatment and at approximately two-week intervals for about three months, then periodically. In patients with collagen vascular disease or who are exposed to other drugs known to affect the white cells or immune response, particularly when there is impaired renal function, captopril should be used only after an assessment of benefit and risk, and then with caution. All patients treated with captopril should be told to report any signs of infection (e.g.,

sore throat, fever). If infection is suspected, perform white cell counts without delay. Since discontinuation of captopril and other drugs has generally led to prompt return of the white count to normal, upon confirmation of neutropenia (neutrophil count $<1000/\text{mm}^3$) withdraw captopril and closely follow the patient's course. **Proteinuria:** Total urinary proteins >1 g per day were seen in about 0.7 percent of patients on captopril. About 90% of affected patients had evidence of prior renal disease or received high doses (>150 mg/day), or both. The nephrotic syndrome occurred in about one-fifth of proteinuric patients. In most cases, proteinuria subsided or cleared within 6 months whether or not captopril was continued. The BUN and creatinine were seldom altered in the proteinuric patients. **Hypotension:** Excessive hypotension was rarely seen in hypertensive patients but is a possible consequence of captopril use in salt/volume depleted persons (such as those treated vigorously with diuretics), patients with heart failure or those patients undergoing renal dialysis. (See PRECAUTIONS: Drug Interactions.) In heart failure, where the blood pressure was either normal or low, transient decreases in mean blood pressure $>20\%$ were recorded in about half of the patients. This transient hypotension is more likely to occur after any of the first several doses and is usually well tolerated, although rarely it has been associated with arrhythmia or conduction defects. A starting dose of 6.25 or 12.5 mg tid may minimize the hypotensive effect. Patients should be followed closely for the first 2 weeks of treatment and whenever the dose of captopril and/or diuretic is increased.

BECAUSE OF THE POTENTIAL FALL IN BLOOD PRESSURE IN THESE PATIENTS, THERAPY SHOULD BE STARTED UNDER VERY CLOSE MEDICAL SUPERVISION. Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible. The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure. These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of captopril as soon as possible. Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment. If oligohydramnios is observed, captopril should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury. Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function. While captopril may be removed from the adult circulation by hemodialysis, there is inadequate data concerning the effectiveness of hemodialysis for removing it from the circulation of neonates or children. Peritoneal dialysis is not effective for removing captopril; there is no information concerning exchange transfusion for removing captopril from the general circulation. When captopril was given to rabbits at doses about 0.8 to 70 times (on a mg/kg basis) the maximum recommended human dose, low incidences of craniofacial malformations were seen. No teratogenic effects of captopril were seen in studies of pregnant rats and hamsters. On a mg/kg basis, the doses used were up to 150 times (in hamsters) and 625 times (in rats) the maximum recommended human dose. **Hepatic Failure:** Rarely, ACE inhibitors have been associated with a syndrome that starts with cholestatic jaundice and progresses to fulminant hepatic necrosis and (sometimes) death. The mechanism of this syndrome is not understood. Patients receiving ACE inhibitors who develop jaundice or marked elevations of hepatic enzymes should discontinue the ACE inhibitor and receive appropriate medical follow-up.

PRECAUTIONS: General: Impaired Renal Function — Hypertension — Some patients with renal disease, particularly those with severe renal artery stenosis, have developed increases in BUN and serum creatinine. It may be necessary to reduce captopril dosage and/or discontinue diuretic. For some of these patients, normalization of blood pressure and maintenance of adequate renal perfusion may not be possible. Heart Failure — About 20% of patients develop stable elevations of BUN and serum creatinine $>20\%$ above normal or baseline upon long-term treatment. Less than 5% of patients, generally those with severe preexisting renal disease, required discontinuation of treatment due to progressively increasing creatinine. (See DOSAGE AND ADMINISTRATION, ADVERSE REACTIONS: Altered Laboratory Findings.) **Hyperkalemia:** Elevations in serum potassium have been observed in some patients treated with ACE inhibitors, including captopril. When treated with ACE inhibitors, patients at risk for the development of hyperkalemia include those with: renal insufficiency; diabetes mellitus; and those using concomitant potassium-sparing diuretics, potassi-

um supplements or potassium-containing salt substitutes; or other drugs associated with increases in serum potassium. In a trial of type I diabetic patients with proteinuria, the incidence of withdrawal of treatment with captopril for hyperkalemia was 2% (4/207). In two trials of normotensive type I diabetic patients with microalbuminuria, no captopril group subjects had hyperkalemia (0/116). (See PRECAUTIONS: Drug Interactions; ADVERSE REACTIONS: Altered Laboratory Findings.) **Cough —** Presumably due to the inhibition of the degradation of endogenous bradykinin, persistent nonproductive cough has been reported with all ACE inhibitors, always resolving after discontinuation of therapy. ACE inhibitor-induced cough should be considered in the differential diagnosis of cough. **Valvular Stenosis —** A theoretical concern, for risk of decreased coronary perfusion, has been noted regarding vasodilator treatment in patients with aortic stenosis due to decreased afterload reduction. **Surgery/Anesthesia —** If hypotension occurs during surgery or anesthesia, and is considered due to the effects of captopril, it is correctable by volume expansion. **Hemodialysis:** Recent clinical observations have shown an association of hypersensitivity-like (anaphylactoid) reactions during hemodialysis with high-flux dialysis membranes (e.g., AN69) in patients receiving ACE inhibitors. In these patients, consideration should be given to using a different type of dialysis membrane or a different class of medication. (See WARNINGS: Anaphylactoid reactions during membrane exposure). **Pregnancy:** Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible. **Drug Interactions: Hypotension — Patients on Diuretic Therapy —** Precipitous reduction of blood pressure may occasionally occur within the first hour after administration of the initial captopril dose in patients on diuretics, especially those recently placed on diuretics, and those on severe dietary salt restriction or dialysis. The possibility can be minimized by either discontinuing the diuretic or increasing the salt intake about one week prior to initiation of captopril therapy or by initiating therapy with small doses (6.25 or 12.5 mg). Alternatively, provide medical supervision for at least one hour after the initial dose. **Agents Having Vasodilator Activity —** In heart failure patients, vasodilators should be administered with caution. **Agents Causing Renin Release:** Captopril's effect will be augmented by antihypertensive agents that cause renin release. **Agents Affecting Sympathetic Activity —** The sympathetic nervous system may be especially important in supporting blood pressure in patients receiving captopril alone or with diuretics. Beta-adrenergic blocking drugs add some further antihypertensive effect to captopril, but the overall response is less than additive. Therefore, use agents affecting sympathetic activity (e.g., ganglionic blocking agents or adrenergic neuron blocking agents) with caution. **Agents Increasing Serum Potassium —** Give potassium-sparing diuretics or potassium supplements only for documented hypokalemia, and then with caution, since they may lead to a significant increase of serum potassium. Use potassium-containing salt substitutes with caution. **Inhibitors of Endogenous Prostaglandin Synthesis —** Indomethacin and other non-steroidal anti-inflammatory agents may reduce the antihypertensive effect of captopril, especially in low renin hypertension.

Lithium — Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be coadministered with caution and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity. **Drug/Laboratory Test Interaction:** Captopril may cause a false-positive urine test for acetone. **Carcinogenesis, Mutagenesis and Impairment of Fertility:** Two-year studies with doses of 50 to 1350 mg/kg/day in mice and rats failed to show any evidence of carcinogenic potential. The high dose in these studies is 150 times the maximum recommended human dose of 450 mg, assuming a 50-kg subject. On a body-surface-area basis, the high doses for mice and rats are 13 and 26 times the maximum recommended human dose, respectively. Studies in rats have revealed no impairment of fertility.

Pregnancy Categories C (first trimester) and D (second and third trimesters).

See WARNINGS: Fetal/Neonatal Morbidity and Mortality. Nursing Mothers: Concentrations of captopril in human milk are approximately one percent of those in maternal blood. Because of the potential for serious adverse reactions in nursing infants from captopril, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of CAPOTEN (captopril) to the mother. (See PRECAUTIONS: Pediatric Use.) **Pediatric Use:** Safety and effectiveness in children have not been established. There is limited experience reported in the literature with the use of captopril in the pediatric population; dosage, on a weight basis, was generally reported to be comparable to or less than that used in adults. Infants, especially newborns, may be more susceptible to the adverse hemodynamic effects of captopril. Excessive, prolonged and unpredictable decreases in blood pressure and associated complications, including oliguria and seizures, have been reported. CAPOTEN should be used in children only if other measures for controlling blood pressure have not been effective.

ADVERSE REACTIONS: Reported incidences are based on clinical trials involving approximately 7000 patients. **Renal:** About one of 100 patients developed proteinuria (see WARNINGS). Renal insufficiency, renal failure, nephrotic syndrome, polyuria, oliguria, and urinary frequency in 1 to 2 of 1000 patients. **Hematologic:** Neutropenia/agranulocytosis has occurred (see WARNINGS). Anemia, thrombocytopenia, and pancytopenia have been reported. **Dermatologic:** Rash, (usually maculopapular, rarely urticarial) often with pruritus, and sometimes with fever and eosinophilia, in about 4 to 7 of 100 patients (depend-

ing on renal status and dose), usually during the first four weeks of therapy. Pruritus, without rash, occurs in about 2 of 100 patients. A reversible associated pemphigoid-like lesion, and photosensitivity, have also been reported. Flushing or pallor has been reported in 2 to 5 of 1000 patients. **Cardiovascular:** Hypotension may occur; see WARNINGS and PRECAUTIONS (Drug Interactions) for discussion of hypotension with captopril therapy. Tachycardia, chest pain, and palpitations have each been observed in about 1 of 100 patients. Angina pectoris, myocardial infarction, Raynaud's syndrome, and congestive heart failure in 2 to 3 of 1000 patients. **Dysgeusia:** Approximately 2 to 4 (depending on renal status and dose) of 100 patients developed a diminution or loss of taste perception; taste impairment is reversible and usually self-limited even with continued drug use (2 to 3 months). **Angioedema:** Angioedema involving the extremities, face, lips, mucous membranes, tongue, glottis or larynx has been reported in approximately one in 1000 patients. Angioedema involving the upper airways has caused fatal airway obstruction. (See WARNINGS: Angioedema.) **Cough:** Cough has been reported in 0.5-2% of patients treated with captopril in clinical trials. (See PRECAUTIONS: General, Cough). The following have been reported in about 0.5 to 2 percent of patients but did not appear at increased frequency compared to placebo or other treatments used in controlled trials: gastric irritation, abdominal pain, nausea, vomiting, diarrhea, anorexia, constipation, aphthous ulcers, peptic ulcer, dizziness, headache, malaise, fatigue, insomnia, dry mouth, dyspnea, alopecia, paresthesias. Other clinical adverse effects reported since the drug was marketed are listed below by body system. In this setting, an incidence or causal relationship cannot be accurately determined. **Body as a whole:** Anaphylactoid reactions (See WARNINGS: Anaphylactoid and possibly related reactions and PRECAUTIONS: Hemodialysis). **General:** Asthenia, gynecostasia. **Cardiovascular:** Cardiac arrest, cerebrovascular accident/insufficiency, rhythm disturbances, orthostatic hypotension, syncope. **Dermatologic:** Bullous pemphigus, erythema multiforme (including Stevens-Johnson syndrome), exfoliative dermatitis. **Gastrointestinal:** Pancreatitis, glossitis, dyspepsia. **Hematologic:** Anemia, including aplastic and hemolytic. **Hepatobiliary:** Jaundice, hepatitis, including rare cases of necrosis, cholestasis. **Metabolic:** Symptomatic hyponatremia. **Musculoskeletal:** Myalgia, myasthenia. **Nervous/Psychiatric:** Ataxia, confusion, depression, nervousness, somnolence. **Respiratory:** Bronchospasm, eosinophilic pneumonitis, rhinitis. **Special Senses:** Blurred vision. **Urogenital:** Impotence. As with other ACE inhibitors, a syndrome has been reported which may include: fever, myalgia, arthralgia, interstitial nephritis, vasculitis, rash or other dermatologic manifestations, eosinophilia and an elevated ESR. **Fetal/Neonatal Morbidity and Mortality. See WARNINGS: Fetal/Neonatal Morbidity and Mortality. Altered Laboratory Findings: Serum Electrolytes: Hyperkalemia:** small increases in serum potassium, especially in patients with renal impairment (see PRECAUTIONS). **Hyponatremia:** particularly in patients receiving a low sodium diet or concomitant diuretics. **BUN/Serum Creatinine:** Transient elevations of BUN or serum creatinine especially in volume or salt depleted patients or those with renovascular hypertension may occur. Rapid reduction of longstanding or markedly elevated blood pressure can result in decreases in the glomerular filtration rate and, in turn, lead to increases in BUN or serum creatinine. **Hematologic:** A positive ANA has been reported. **Liver Function Tests:** Elevations of liver transaminases, alkaline phosphatase, and serum bilirubin have occurred.

OVERDOSAGE: Primary concern is correction of hypotension. Volume expansion with an I.V. infusion of normal saline is the treatment of choice for restoration of blood pressure. While captopril may be removed from the adult circulation by hemodialysis, there is inadequate data concerning the effectiveness of hemodialysis for removing it from the circulation of neonates or children. Peritoneal dialysis is not effective for removing captopril; there is no information concerning exchange transfusion for removing captopril from the general circulation.

DOSAGE AND ADMINISTRATION: CAPOTEN should be taken one hour before meals. In hypertension, CAPOTEN may be dosed bid or tid. Dosage must be individualized; see DOSAGE AND ADMINISTRATION section of package insert for detailed information regarding dosage in hypertension, heart failure, LVD after myocardial infarction and diabetic nephropathy. Because CAPOTEN is excreted primarily by the kidneys, dosage adjustments are recommended for patients with impaired renal function. (See WARNINGS: Anaphylactoid reactions during membrane exposure and PRECAUTIONS: Hemodialysis). **[Consult package insert before prescribing CAPOTEN (captopril).]**

HOW SUPPLIED: Available in tablets of 12.5 mg in bottles of 100 and 1000; 25 mg in bottles of 100 and 1000; 50 mg in bottles of 100 and 1000; 100 mg in bottles of 100; and in Unimatic® unit-dose packs containing 100 tablets.

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SECOND OF TWO PARTS

Dusting for prints

Forensic scientists use sophisticated computer programs to identify fingerprints, blood and other body fluids.

BY RICK ASA

The national automated fingerprint identification system went on-line in the mid-1980s. The first time it was used in Los Angeles, investigators conducted an automated fingerprint search of 1.7 million records and obtained a match in 20 minutes. It was estimated that the same identification would have taken one human examiner 67 years, said Marian Caporusso, assistant director of the Chicago Police Department Crime Lab.

By 1993, the FBI had converted the prints of 24 million criminals into mathematical formulas containing the characteristics of each fingerprint, which could then be compared with others. The FBI said that by 1995, fingerprint scanners tied to a national computer network will

be used in some police cruisers.

Incredible results have already been obtained. In 1992, an ex-burglar was convicted of having murdered a widow in the Bronx in 1974. Fingerprints were found on a brandy glass and a window, but lay dormant in police files for 17 years until a detective tried cross-checking them in the new data bases of the FBI and several states. The check matched the prints with those of a man who was living in South Carolina and had been arrested on an incest charge there.

(Continued on page 10)



Forensic medicine

(Continued from page 9)

In 1989, Illinois became one of the first 15 states to pass legislation calling for the collection of blood standards from convicted sex offenders to help track and identify them. A computer program automatically sizes the bands

that result from a DNA test and can quickly find a possible match.

In one of the first cases using a sex offender data base, state investigators in Minnesota were able to preliminarily match the DNA profile from semen taken in a sexual assault case with the profile of a recently released sex offender. Under the law, that was probable cause

to obtain a blood sample from the man, which was run against the semen sample for a definitive match.

Computers can also improve administration of a forensic operation, facilitating data searches to identify trends and the reconstruction of crime scenes through the use of graphics software.

There is also increasing interest in

forensic applications in the social science and public health fields, said Randy Hanzlick, MD, chairman of the biology/pathology section of the Chicago-based American Society of Clinical Pathologists and an assistant professor of pathology at Emory University. The National Bureau of Labor Statistics, for example, has begun to apply forensic

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*In 1989, Illinois
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to help track and
identify them.*

principles to its investigations of death due to injury, to improve the quality and scope of the results.

THE COOK COUNTY Medical Examiner's office is participating in a national study of heart disease progression, which has shown, through autopsies, early pathology in otherwise healthy young people. Those findings could lead to earlier prevention, diagnosis and treatment of heart disease, said Cook County Medical Examiner Edmund Donoghue Jr., MD.

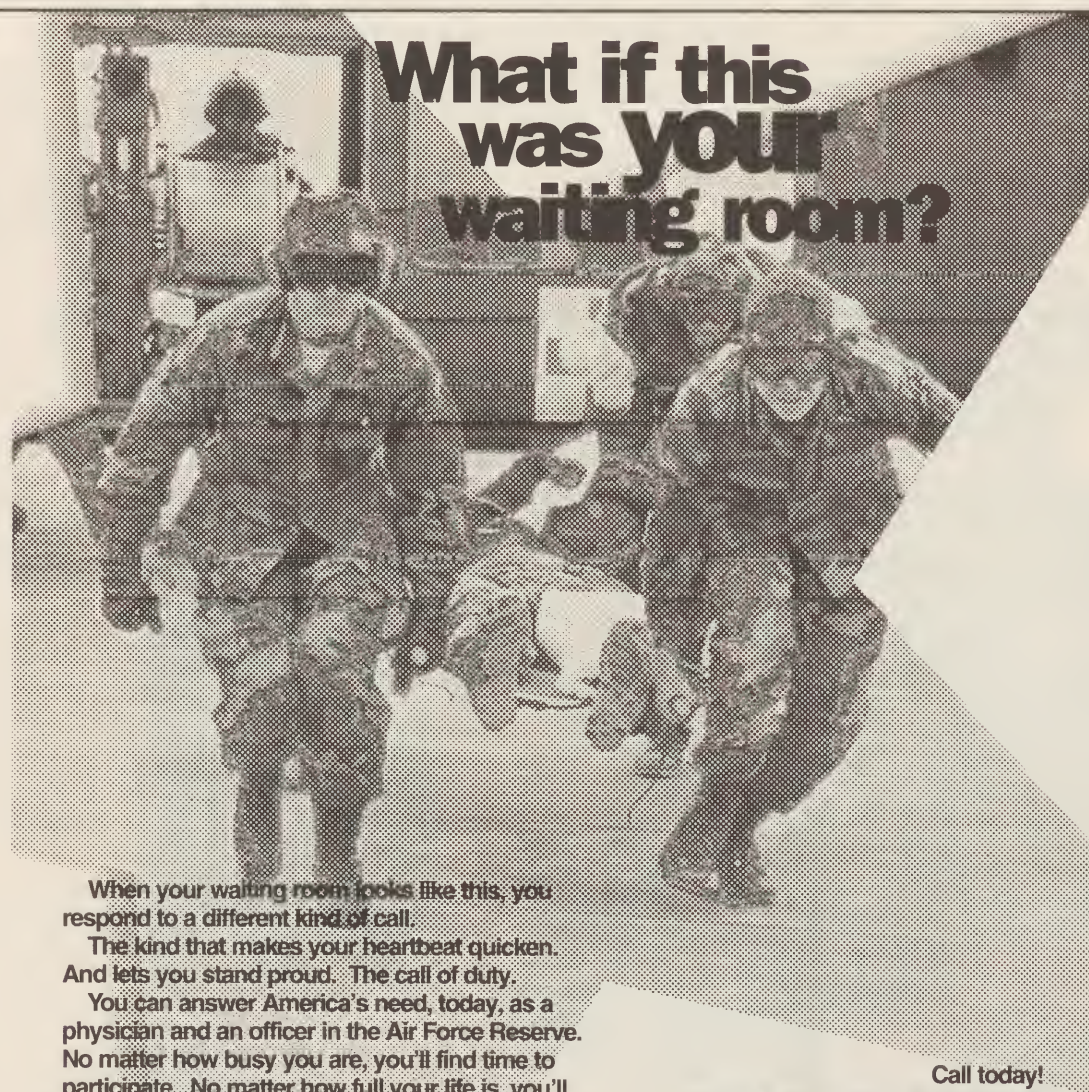
"The problem of homicide has been raised as a public health problem in this country and is being treated by the Centers for Disease Control and Prevention as an epidemiological problem," said Joseph Peterson, graduate program director and professor of criminal justice at the University of Illinois at Chicago. "In trying to figure out the whole social context of violence patterns and then developing suitable prevention programs, the forensic pathologist has to be a member of that team."

The Cook County Medical Examiner's office offers a fully accredited forensic science residency program to physicians who have a background in clinical pathology, one of relatively few such programs in the country, Dr. Donoghue said.

There are 39 approved residency programs, most freestanding, a few university-based, and 500 to 600 working forensic pathologists in the United States, a small number that is currently meeting the need, he said. "We have some concerns, however, about health system reform that may limit the number of specialists. If it limits pathology residents, we could be adversely affected."

The number of physicians, specifically pathologists, who choose forensics as a career has been limited partly by financial constraints, noted Dr. Hanzlick. Even experienced medical examiners earn far less than most physicians do, he added.

About 30 states still use a coroner, a largely administrative position, Dr. Hanzlick continued. In those areas, autopsies and medical examinations are typically conducted by local physicians. Although



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Drs. Hanzlick and Donoghue said coroners do a credible job, they noted that the specific training included in medical examiner programs, such as ballistics, may not be available or offered in a coroner's jurisdiction.

"In [jurisdictions] that have made a move to a medical examiner, they now realize more than ever that death involves a lot of medical issues," Dr. Hanzlick said. "It's not just somebody getting shot and killed. A medical background can raise many red flags." He added that one drawback is the greater expense involved in switching to a medical examiner system.

Dr. Donoghue stressed that not every jurisdiction needs a medical examiner. The Cook County Medical Examiner's office, for example, covers half the population of the state of Illinois, a number greater than the total population in many states.

The added sophistication that forensic pathologists and other medically trained specialists can bring to the forensic field could help standardize more of the criminal investigation system, Dr. Hanzlick said. That system is subject to "tremendous variance" across the country. "One

case can be treated as an accident in one state and a homicide in another."

He also noted that police-run labs are geared toward prosecution. "For example, someone might be stopped for DUI and the blood test is .20, which is enough to convict, so the investigators and prosecution may not look for cocaine or other drugs on a routine basis.

"The other problem is there hasn't been quality control, although there are jurisdictions now in which lab technicians have to take quality-control records with them to court," Dr. Hanzlick continued. "I've never been asked about quality control myself, and I have

testified as an expert at many trials."

WHETHER THE EXPANDED scope of forensic science will attract more physicians to the field remains to be seen. Dr. Donoghue said his office typically attracts recruits from hospitals, which send their pathologists for forensic training. Most don't understand what the office does when they start but later find it "interesting and realize we are answering some important questions," he noted.

Dr. Hanzlick said forensic pathology is enticing more medically trained young people than in the past, but that is mostly related to where they received their basic pathology training. "If they are

exposed to a good system, they see the possibilities and get excited about it.

"There is an old Latin phrase that many forensic pathologists use. It says, 'This is the place where the dead delight to serve the living,'" Dr. Hanzlick added. "There can be a burnout factor, especially after you've testified in court a couple hundred times. But the great thing about it is no matter how long you've been doing it, you see something new that challenges you all the time."

"A computer can pick out a fingerprint, but it still takes a human to verify it and go to court to testify about it, and with DNA, the major issue is still interpretation," Peterson concluded. ■

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August 1994

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Violet Eggert, Tinley Park – physician and surgeon license reprimanded; controlled substance license placed on indefinite probation for a minimum of one year after picking up a prescription that was authorized for another individual and using it for herself.

Edwin Ekong, Chicago – physician and surgeon license placed on probation for five years due to felony conviction.

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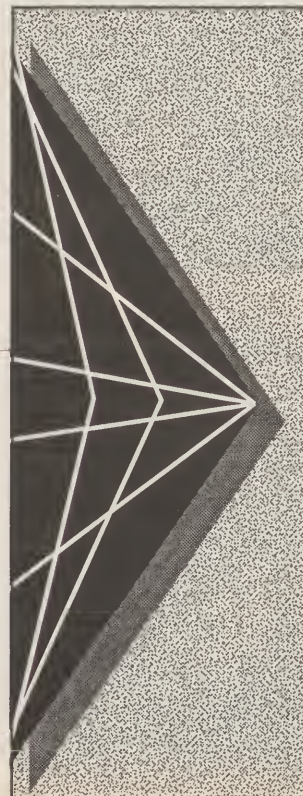
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Feasibility study

(Continued from page 1)

rural areas, which often have only one hospital and a pressing need for primary care physicians and specialists, managed care still has only minimal influence, according to the study.

VIRTUALLY ALL ILLINOIS physicians have some managed care patients in their practices, but few have participated in capitation-based contracting, the study revealed. The results also showed that the state's HMO market is expected to expand.

Most managed care in Illinois is characterized by utilization management that

is driven by insurers, not physicians. And although some aggressive hospital-based initiatives are focused on building alliances with physicians to achieve vertical integration, most efforts are directed at regional expansion through horizontally aligned hospital systems, according to the study.

"Clearly, the Society has more than one kind of member, and consequently [we] must understand and respond to all their needs," Dr. Roman said. "We don't have a policy position that favors managed care over fee for service. We just need to represent all our members more effectively in a managed care scenario."

ISMS can best serve its members by

equipping them to become the architects of the emerging health care delivery system, said study team leader Carol Emmott, PhD, a partner with the executive recruiting and consulting firm SpencerStuart, which recently affiliated with Health Direction. The Society's services should help empower physicians and patients, expand physicians' options and enhance their freedom to choose from a wide array of favorable practice options, she said. "Through these strategies physicians can become the managers, not the 'managees,' in our managed care-oriented future."

Study team member John Ray added that the inability to develop complex

Member survey backs feasibility study

BY KATHLEEN FURORE

Loss of autonomy and lack of control in decision-making are the most significant and troubling changes Illinois physicians face with the increasing penetration of managed care. That was just one finding of an ISMS telephone survey of 300 members conducted by Coldwater Corp. of Ann Arbor, Mich. The Coldwater results support findings from the just-completed phase-one feasibility study conducted by Health Direction Inc., which revealed that most Illinois physicians already participate in some managed care plans.

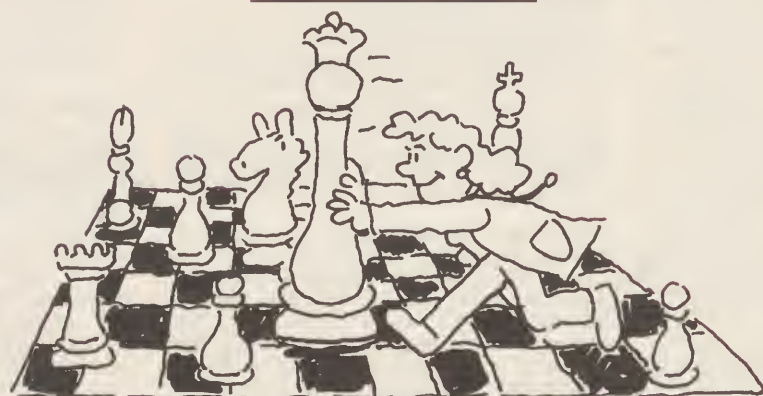
The membership study showed that 87 percent of physician-respondents participate in some type of managed care plan. "While the current state of managed care is not satisfactory for physicians, the vast majority of them already are involved," said Mary Lukens, a Coldwater researcher and partner. "Consequently, those who want to have significant input into the formation of health care delivery systems need services that will help make managed care more physician-driven."

Like the feasibility study, the Coldwater data indicated that managed care is expanding in Illinois. Sixty-two percent of respondents said managed care patient activity increased during the past year, while 47 percent said their traditional private insurance patient activity has decreased. According to the survey, 86 percent of respondents said it is more important for ISMS to use its available resources to help them maintain control over their practices, rather than to try to increase physician income. Seventy-six percent said they would like resources to be used to increase physician control over managed care more than to maintain or increase fee-for-service activity. In addition, 70 percent wanted ISMS to help increase physician input in utilization review and quality assurance standards more than to control the access third-party payers have to UR and quality assurance information.

Sixty-two percent said they want the Society to provide support services that will help them maximize their position in the managed care plans in which they already participate.

Those findings bolster the feasibility study's recommendation that ISMS implement services to promote physician-driven managed care, Lukens said. "In 1976, ISMS actively responded to the liability crisis by forming ISMIE so physicians wouldn't lose coverage and could continue their practices. Now there's a similar situation with managed care, and the Society is moving to make sure physicians have input. Managed care is here to stay, and it will work much better if physicians play an integral leadership role." ■

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and expensive infrastructures needed to thrive in a managed care world impedes physicians who want to take control. "This is where ISMS can help members who want to move into managed care. The Society can continue its strong tradition as an enabling organization by developing the capacity to help physicians create local capitation-based medical organizations."

"The battle is on in every marketplace for the predominant model that will carry into the future," Emmott explained. "Left to their own devices, insurance companies will keep control. Unless Illinois providers assert themselves, it could be that the state will stagnate in an insurance-driven model that doesn't engage physicians in design and guidance of the system. That would lead to a vastly inferior product for physicians and their patients."

"It is highly favorable for physicians to link with hospitals because that model will integrate a full continuum of care and result in cost savings," Emmott continued. "With that kind of linkage, you get referral patterns and a collegiality that enhance quality of care. In an insurance-driven system, there is no way a disinterested utilization review nurse 250 miles away will knit together that kind of continuum of care. Patients might be sent 45 miles one way for an MRI and 45 miles in the opposite direction for maternity care."

The new service options ISMS will evaluate in its business plan would provide the administrative help physicians need to market their practices, assume risk and compete in the business-oriented atmosphere of managed care, Dr. Roman said. "Right now most physicians [in managed care settings] aren't in decision-making roles. Through our new business plan, we'll be looking at ways to make managed care physician-driven as opposed to insurance-driven."

"Physicians are concerned about giving up autonomy," Emmott said. "But they're giving up individual autonomy to gain collective influence. By linking, physicians can collectively innovate in ways they never could before, and they have the coherence of team members working together on a daily basis. There are some very positive things that happen clinically, and patients are far better served."

ISMS wants to create a physician-friendly service arm, possibly in the form of a management services organization, Dr. Roman said. In addition, the Society is examining ways to help physicians continue to make critical decisions about

patient care, he noted. ISMS' toll-free action line and Lawyer Referral Network, as well as the consultant referral service scheduled to debut this month, exemplify programs the Society is providing for members, he said.

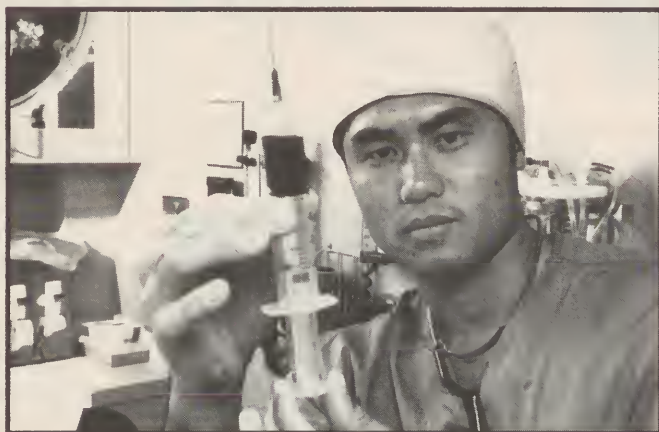
"ISMS has a long history of responding to members' needs and interests," he noted. "We can't reverse the trend toward managed care, but we can help shape the system so that physicians and their patients have more input and due process protection as managed care structures take hold. We're committed to helping our members move successfully into a physician-driven managed care marketplace."

ISMS referral networks serve members

Although ISMS is still in the study phase of its plan to become a comprehensive managed care resource for physicians, the Society has already developed services to help members achieve their professional goals in the evolving marketplace.

The Lawyer Referral Network, launched in May, includes more than 60 attorneys from around the state who can provide members with legal help in areas such as managed care arrangements, licensure, contracts, medical staff issues, taxation, fraud and abuse concerns, and Medicare and Medicaid. Each attorney is experienced in health care and has a track record of physician advocacy. Physicians may obtain lawyer referrals by calling (800) MD-ASIST.

The new ISMS consultant referral service will be available soon. It will give members access to consultants with expertise in managed care and practice management. All consultants participating in the service are being screened by ISMS. Watch Illinois Medicine for details.



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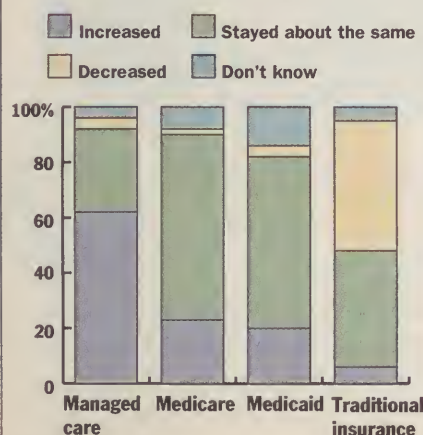
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IDPA awards grants to poison control centers

PAGE 2

Illinois Medicine

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Helping patients escape the past

PAGE 8

State issues guidelines to fight domestic violence

RECOMMENDATIONS: Agencies emphasize the treatment of batterers. BY KATHLEEN FUIORE

[SPRINGFIELD] The Illinois Domestic Violence Council, under the direction of the Illinois Department of Public Aid, has released the first in a series of statewide guidelines for programs working with perpetrators of domestic violence. Announced last month by Gov. Jim Edgar, the Illinois guidelines for dealing with domestic abuse batterers "will help ensure quality, consistent programs throughout Illinois and, more importantly, will help protect the safety of victims."

The guidelines were created with input from physicians, researchers and experts in related fields.

"Traditionally, the emphasis has been on treating victims of domestic violence, rather than abusers, but that's changing," Edgar said. "It's critical that we begin solving the problem head-on by working with batterers to change their behavior and prevent senseless violence. Until we get at the root of the problem, cases of domestic violence will

(Continued on page 12)

State expands federal immunization program

PREVENTION: Physicians can provide free vaccines to eligible children. BY KATHLEEN FUIORE

[SPRINGFIELD] The Illinois Department of Public Health is encouraging Illinois physicians to participate in the new Illinois Vaccines for Children Plus program. Under the program, all Illinois children 18 and under whose insurance does not cover immunizations are eligible for free vaccines regardless of their ability to pay or the place at which the vac-

cines are given.

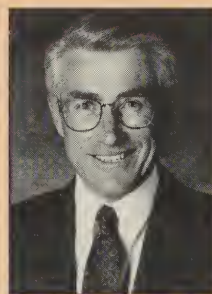
"Illinois' VFC Plus program aims to guarantee that cost and who administers the vaccine will no longer be a barrier to immunizing our children," said Illinois' first lady Brenda Edgar, who announced the program Oct. 23. "Ensuring children receive the proper immunizations at the proper ages is the

(Continued on page 12)

Republican control portends physician-friendly Statehouse

GENERAL ELECTION: Voters sweep GOP into the majority.

Capitalizing on Gov. Jim Edgar's landslide victory over Dawn Clark Netsch, Illinois Republicans captured enough seats to win the majority in the Illinois House, which had been under Democratic control for the past 11 years. The GOP



Edgar

win - fueled by nationwide voter dissatisfaction with the Democratic agenda - means Republicans now control both the General Assembly and the governor's mansion for the first time since 1971. "This election was an incredible victory for ISMS. Our gains could not have been realized without IMPAC, the Society's political arm. It was decisively involved in contests statewide," said ISMS President Alan M. Roman, MD.

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INSIDE

Medical savings accounts help rein in costs



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Use caution in selling a practice

RISK: Physicians should seek legal help to negotiate purchase agreements. BY KATHLEEN FUIORE

[CHICAGO] As managed care proliferates, hospitals and insurance companies are wooing physicians with attractive purchase and employment offers. Physicians are responding by selling their practices in record numbers, according to consultants and attorneys who specialize in practice management.

Doctors must beware of the potential risks in selling the businesses they've worked to build. "Physicians have to weigh the advantages and disadvantages of becoming an employee of another entity," said Judee Gallagher, a Chicago attorney in private practice and a participant in ISMS' Lawyer Referral Network. "The way financial agreements are structured, the amount of the purchase price and compensation arrangements vary greatly. That's why anyone who's thinking of selling a practice must have good legal representation by someone who understands the issues."

Those issues include valuation of the practice, negotiation

of terms of employment and contractual concerns such as termination agreements and restrictive covenants, according to Gallagher and health care consultants Connie Henderson-Damon and Jimmy Dale Love.

MANAGED CARE

"You have to determine exactly what you're selling. What are the hard, tangible assets? Is the buyer buying your accounts receivables? And how are those things being valued?" said Henderson-Damon, principal of the Oak Park-based Sage Group. "If you have any accounts six months or older, for example, there is little chance of collecting. Buyers are looking for efficiently run practices that have cut costs, use staffs efficiently and are operationally run well. If your overhead is 75 percent, the hospital will have to hire someone to come in and get things in order."

(Continued on page 15)



Chip Zellet



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FORMER CHICAGO BULLS guard John Paxson records a public service announcement promoting ISMS' AIDS and STD awareness program aimed at Illinois teens.

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Poison control centers receive IDPA grants

[SPRINGFIELD] The Illinois Department of Public Aid in September awarded grants totaling \$150,000 to the state's two poison control centers operated by Rush-Presbyterian-St. Luke's Medical Center in Chicago and SwedishAmerican Hospital in Rockford. The funds will be used to strengthen operations of the centers, which handle more than 80,000 phone calls a year, according to IDPA Director Robert Wright.

"The state of Illinois recognizes that the centers operate under financial pressures to provide a valuable community service for which they receive no money," he said. "To ease those pressures and to assure that the services continue to be available to all Illinois residents, the state will provide grants to their operations."

IDPA funded the grants through Medicaid because so many recipients benefit from the free and often life-saving information the centers provide, an IDPA spokesperson said. "We're hearing reports from the medical community of an ever-increasing variety of drugs and other substances being used by people,"

Wright added. "These grants will help the centers stay abreast of how to handle new substances and share the information with Medicaid providers and the entire medical community."

Rush's poison control center, which takes more than 51,000 calls annually from Cook and the collar counties, will receive \$100,000 during the current fiscal year, Wright noted. SwedishAmerican's center, which serves 96 Downstate counties and receives more than 32,000 calls each year, will receive \$50,000.

The grants are consistent with ISMS Board of Trustees' policy adopted in April, which supports state funding for poison control centers in Illinois.

"The state's support gives a real boost to the operations of the center, which provides fast, expert advice on the toxic effects and antidotes for thousands of substances," said Raul Ponte, MD, medical director of the SwedishAmerican poison control center. "The money means the center's employees can continue to avert medical catastrophes every day."

The grants could ultimately result in substantial savings, said Jerrold Leikin, MD, medical director of the Rush center. "We have learned over the years that every dollar spent on poison control saves at least \$7.75 in medical spending." ■

Gov. Edgar expands Project Success

[SPRINGFIELD] Fifty-one additional communities have been selected to participate in Project Success, an initiative developed under Gov. Jim Edgar's direction to extend health and human service programs to needy schoolchildren. The program, which was piloted in six communities in 1992, now includes 90 neighborhoods and communities serving 200 elementary schools throughout the state, according to the governor's office.

"Under our nationally recognized Project Success program, communities and neighborhoods marshal existing state and community resources on

behalf of children whose health and family problems adversely affect them in the classroom," Edgar said. The governor added that he hopes to eventually expand the program to include all Illinois communities.

Newly selected communities receive a one-time start-up grant of \$15,000 to implement the program, which integrates services and activities into elementary schools. Participating schools provide hearing and vision programs, preventive health screenings, vaccinations, counseling services, tutoring, after-school recreational activities and substance abuse prevention programs. Local governing boards composed of parents, educators, business and community leaders and service providers make certain that students and their



Amy Rothblatt

ISMS PRESIDENT

Alan M. Roman, MD (right), watches as Gov. Jim Edgar signs H.B. 1391. The law creates an osteoporosis prevention and education program aimed at raising awareness about the prevention, causes and treatments of the disease.

Children's Memorial opens violent injury center

[CHICAGO] To curb the frequency and severity of violent injuries to young people, the Children's Memorial Medical Center in Chicago has created a Violent Injury Prevention Center. Its

focus is preventing the two major causes of violent death in children – firearm injuries and child abuse.

"As health care professionals, we can no longer just treat the results of violence against children without seeking to stop what is causing their injuries and deaths," said Katherine Kaufer Christoffel, MD, the center's medical director and a pediatrician. She also founded and serves as chairperson of the Handgun Epidemic Lowering Plan Network of Concerned Professionals, or HELP, which is a national organization dedicated to combating handgun violence by defining it as a public health issue. HELP is now part of the violence prevention center, the spokesperson said.

The center offers a variety of programs and services, including the use of art therapy and community social services to promote victims' psychological and emotional healing and minimize the recurrence of injuries, the spokesperson noted. The multidisciplinary team delivering the services address the varying problems surrounding child abuse, the spokesperson added. In addition, the center will develop a data base of information about violent injuries to and deaths of Illinois children and will conduct community outreach programs designed to increase awareness about violent handgun injuries.

Funded through contributions, the violence prevention center is one of several programs overseen by the medical center's child advocacy department. "To be a fair, caring institution, it's our responsibility to give something back to our community," said Jan Jennings, hospital president and CEO. "The most important things we can give are our collective knowledge, influence and leadership skills in areas related to children." ■

Saint Joseph Hospital changes name

[CHICAGO] Saint Joseph Hospital on Chicago's North Side became Saint Joseph Health Centers and Hospital in October. The name change is part of the hospital's strategy to create a community-based network of services designed to bring health care closer to patients.

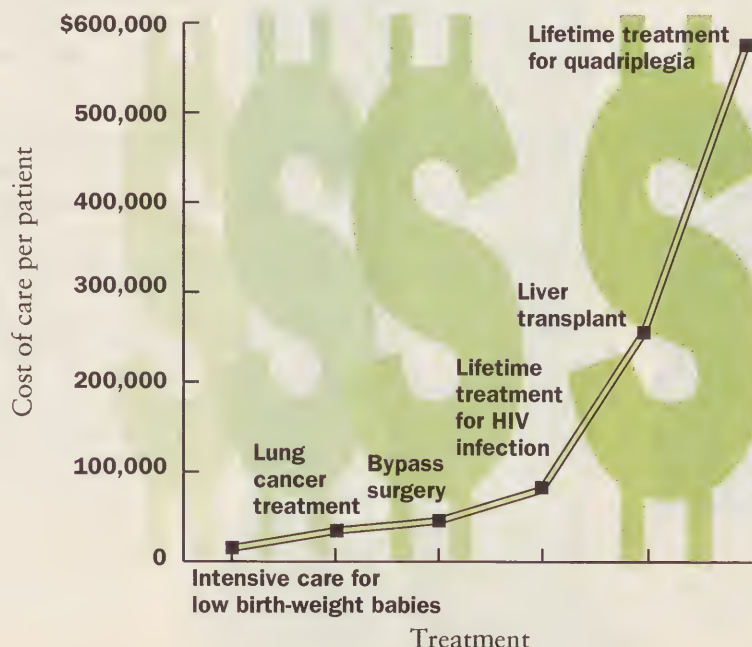
The hospital also announced plans to open two new health centers in the neighborhoods it serves, bringing to 10 the number of outpatient centers throughout metropolitan Chicago that are affiliated with the facility. The centers will include physician offices and offer diagnostic, therapeutic and rehabilitation services as well as community health education programs.

"Working with our physicians and our employees, we are doing the right things to provide what patients, physicians and payers are asking for – quality health care that is both cost-effective and convenient," said Sister Theresa Peck, Saint Joseph president.

In addition to opening the satellite clinics, the hospital will dedicate a new two-room AIDS hospice this month. ■

PHYSICIAN FACTS

Cost of treatment for preventable medical conditions



Source: Health Insurance Association of America, 1994

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Medical savings accounts help rein in costs

REFORM: Patients can save money tax-free to pay for health care expenses. BY RICK PASZKIET

[ALTON] This fall, Gov. Jim Edgar signed H.B. 1066, a bill that allows for the creation of medical savings accounts by changing the state's tax laws. According to the legislation, which was supported by ISMS, MSA contributions and earned interest are not subject to state income taxes unless they are used for nonmedical purposes.

Because of their promise for cost savings and expanded patient choice, MSAs are gaining popularity as a reform option. Tax-free MSAs have also been proposed to increase access to health insurance. MSAs were included in several federal reform proposals, including the Gephardt and Roland-Bilirakis plans, according to the AMA, which along with ISMS supports MSAs as a component of reform.

AMA policy states that patients should have the "opportunity and the responsibility to make a wise prospective choice of physician and financing mechanism,"

said AMA House Speaker Daniel Johnson Jr., MD. MSAs help facilitate that choice because they reward patients for using the system cost-effectively, he said. "The big attraction of MSAs is that they offer a



Dr. Hamilton

way for [the patient] to derive the benefit of that cost-effectiveness instead of the insurance company or the employer."

"One of the problems with our health care system now is that everyone is spending someone else's money," said Robert F. Hamilton, MD, ISMS Sixth District trustee. "MSAs offer a tax-free incentive for people not to spend their money for unnecessary medical services." Although Illinois' new law permits MSAs to be exempt from state taxes, no such immunity from federal taxes has yet been enacted.

With MSAs, employers buy insurance policies that provide catastrophic coverage for 100 percent of the covered costs that exceed a high deductible — \$2,000 or more. Employees make contributions to individual accounts and can then use the funds for future health care needs not covered by the policy. The difference between premiums for traditional coverage and those for catastrophic coverage is then placed in the employees' MSAs.

"The primary advantage of [an MSA] is that it gives a patient a vested interest in the whole health care process," Dr. Hamilton said. "Quite simply, MSAs encourage doctors and patients not to waste. With MSAs, the pre-eminence of a patient's rights and ability to make choices is preserved. The physician and patient make the crucial decisions, such as what type of treatment should be pursued or when the patient should be discharged from the hospital. MSAs give us flexibility."

Studies show that besides increasing patient autonomy, MSAs offer savings to employers, Dr. Hamilton noted. "It is far cheaper to buy catastrophic insurance than a low-deductible more comprehensive policy or any managed care plan," added Dr. Johnson.

MSAs would also reduce the number of uninsured people, Dr. Hamilton said. "Employees have the opportunity with an MSA to build up their own tax-free health care funds, which then can be used when they are between jobs."

Some critics charge that the plans would discourage employees from receiving preventive care like regular checkups. But Dr. Hamilton noted that one compa-

ny's experience indicated just the opposite: Employees at Golden Rule Insurance Co. tended to use MSA funds to pay for routine exams and other preventive services. Since the company began offering the MSA plan in 1993, 90 percent of its employees have switched from the company's \$500-deductible traditional insurance plan to the MSA plan, which carries a \$3,000 deductible.

"Another reason MSAs are attracting attention is that there are lower administrative costs," said Dr. Hamilton. A study conducted by the international actuarial firm Milliman and Robertson projected that over a five-year period, use of MSAs would save \$55.5 billion in administrative costs alone, he added.

"The momentum for MSAs is increasing, but [they haven't] received as much publicity as managed care plans," Dr. Hamilton continued. "MSAs may not be the sole solution in reforming health care, but they are an essential step in curbing costs while allowing patients the freedom to make their own health care decisions."



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REPORT for Illinois Physicians

WILLING PROVIDER LEGISLATION

Illinois does have a "Willing Provider" act, that was passed by the Illinois legislature about 7 years ago. Blue Cross Blue Shield of Illinois (BCBSI) supported this legislation after some BCBSI suggested modifications of the original language were incorporated into the final proposed act. The Illinois Willing Provider act applies to "non-institutional providers" who are defined as persons licensed under the Medical Practice Act of 1987. Only physicians (allopathic (M.D.), osteopathic, and chiropractic) are licensed under that act; consequently, the Willing Provider act does not apply to other providers, such as dentists, podiatrists, pharmacists, or nurse practitioners. In particular, the act does not apply to hospitals nor to HMO's. Insurers and Third Party administrators are allowed to set the terms and conditions under which they will contract with physicians, but these terms may not be unreasonable, and must not result in discrimination against or among any physicians.

BCBSI has several contracted physician networks, all of which are in compliance with the "Willing Provider" act. The Mutual Participation Program is available to all physicians licensed in the State of Illinois, and approximately 76% of all physicians in Illinois, and 85% of those in the Chicago Metropolitan area are participating. This network applies to patients with "usual and customary" (U & C) payment type policies. Physicians accept the BCBSI designated U & C payment as payment in full. Of course, physicians can bill patients for uncovered services, and for any coinsurance and deductible amounts up to the BCBSI determined U & C fee. The BCBSI PPO is also available to any licensed physician who has also signed an MPP agreement. The PPO physician agrees to accept as payment in full the lesser of the physician's billed charges, or the fee indicated in the BCBSI Schedule of Maximum Allowances. Approximately 18,000 physicians have signed BCBSI PPO contracts. As noted above, the Willing Provider act does not apply to BCBSI's HMO (HMO Illinois). However, there are significant credentialing and qualification requirements for HMOI network physicians. The Willing Provider act does apply to BCBSI's point-of-service product, called Managed Care Network Preferred (MCNP). In this product, physicians must meet high standards, including Board Certification, and they must undergo an exacting credentialing process. They must also have previously signed MPP and PPO contracts. Physicians are paid on the same basis as in the PPO. Additionally, BCBSI has set standards for discontinuing new physician enrollment based on objective indicators of the adequacy of the numbers of physicians of a certain specialty in a given geographic area.

BCBSI recognizes that in many States, Willing Provider legislation has been used as an anti-managed care maneuver. However, in Illinois, onerous anti-managed care provisions have been omitted. Willing Provider legislation should prevent discrimination, but if Willing Provider legislation is designed to cripple a managed care organization's ability to create a defined physician network, then such legislation would be unfair and therefore would be opposed by BCBSI and other "Blue" health insurance plans.

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EDITORIAL

The good and the bad in managed care

Managed care is changing health care for physicians and patients alike. Although the methodology and results haven't been verified, different studies are claiming positive and negative results and reflect the ongoing debate on managed care.

One study said that some kinds of cancer were more likely to be diagnosed earlier in older Americans who belong to HMOs than in other patients. Specifically, breast, cervical and colon cancer and melanomas were diagnosed sooner in HMO enrollees. The HCFA study attributed the difference to HMO coverage of such routine screenings as mammograms, Pap smears, fecal blood tests and annual checkups.

Two other studies, however, seem to indicate that managed care cost-containment approaches that limit access to specialists may result in lower-quality care for heart-attack patients. Responding to the Harvard Medical School and Duke University study results, researchers quoted in the Wall Street Journal expressed concern over the growing tendency of managed care plans to curb the use of specialists. That's why before signing a contract, physicians need to be comfortable with the cadre of specialists and the referral process used in the plan.

Another managed care-related issue – practice guidelines – has been in the news again. A Harvard University study and recent court cases suggest that writ-

ten guidelines "have become powerful weapons for plaintiffs in malpractice cases," said the Wall Street Journal.

Yet, used properly, as an educational tool, practice guidelines can be helpful. In late 1993, the Society was concerned about the imposition of practice guidelines by Blue Cross and Blue Shield of Illinois. ISMS worked with the Blues to ensure that these guidelines were consistent with the quality standards set by medical specialties and that the guidelines were not the sole criterion for physician participation in the Blues plan.

Managed care will continue to evolve, with the potential to create benefits and challenges for physicians. ISMS is helping, you, our members who choose to participate in managed care systems to maximize the potential for good and avoid the pitfalls. If the problems are legal, you may call (800) MD-ASIST to gain a referral to a lawyer participating in ISMS' Lawyer Referral Network. If you need help with practice management or administrative matters, an ISMS consultant referral service will be operational soon. You have access to advice from lawyers and consultants through the managed care series in Illinois Medicine. The Society has also commissioned studies to determine your needs and is now working on a business plan to meet them.

Change is certain, and so are the support and advocacy you will continue receiving from ISMS.

PRESIDENT'S LETTER

Giving thanks for the memories

Alan M. Roman, MD



The essence of Thanksgiving is family, our immediate one as well as the family of medicine and of mankind.

Wearing a sweater and jeans, daydreaming shortly after sunrise, I take a walk through the leaves. Sunday is a chance to take it easy, to hang loose. At such times, be they early in the morning or late at night, circumstances seem more fragile and thoughts more vivid because one is alone with them.

Looking at the brilliance of the orange, gold and yellow leaves forming piles under the oaks and maples and listening to the rustling leaves that have yet to fall, you know that whatever they are saying, they have all the answers. As you walk among the leaves, you realize that autumn represents more than days that are growing shorter and nights growing longer. Like the changing seasons, great things happen bit by bit. Day by day.

As it happens in nature, so it goes with people. In the months following Justin's birth, I would lay him on my chest and marvel as his little hand would tightly grasp my finger. We were thrilled with our newcomer, and we wanted to hold him forever. Nothing was too good for the heir to the family name. The first year was one of child care books, Teddy Ruxpin and photo after photo. The day he took his first step we were there with outstretched arms to cushion his fall, and later we walked hand in hand.

Then along came Lindsay, my princess, her pixieish smile preceding the terrible twos. With her, I entered the world of Barbie dolls, dresses and patent leather party shoes.

Before long, he started kicking a soccer ball, got his first allowance and learned to recite the pledge of allegiance. He discovered the tooth fairy, learned to make friends and get along, and attended his first Bears game. Lindsay, for her part, discovered Play-Doh and a large purple dinosaur. She graduated to dance

recitals, hopscotch and a collection of Madame Alexander dolls.

Today, he is into soccer league, riddles, tennis lessons and Super Nintendo video games, all the while attired in polo shirts and jeans. She prefers peanut butter and pizza (not together!), as well as Leaps and Bounds and drop-dead party dresses. My 3-year-old, soon to be 4, has never looked more beautiful.

The day is fast coming when our boy will become a young man, spending more time with friends than with Mom and Dad. An old friend is growing newer every day. I will soon be taking him to dance class and piano lessons, giving him the keys to the family car and teaching him all that I know. Lindsay will soon be sharing secrets with men other than her daddy. But for a short time, our children are still within the realm of our influence.

Eventually as they get stronger and I get weaker, we will swap places. They will hold my hand when necessary to keep me from stumbling. And I will look to them for advice because they will be so much smarter than I ever was and will have had opportunities I never knew.

What I teach Justin and Lindsay, they will teach their children, and so the cycle of life continues. They have brought me only happiness and joy and have validated that my values are in their proper place. They are the objects of my complicated admiration. Perhaps, then, this year we will realize that the essence of Thanksgiving is family, our immediate one as well as the family of medicine and of mankind. We give thanks for our children, our health, our family and our friends.

Much health and happiness and happy Thanksgiving from my family to yours and from all of us at the Illinois State Medical Society.

Quotables

"The aftermath of the health care reform battle is unfolding like a bad mystery novel. The victim had dozens of enemies, but now that he's dead, all of them are finding something nice to say about him — and working hard on their alibis."

— **National Journal**

"Certainly, we couldn't help but be impressed with her eloquence and dedication to health care reform. But that was far outweighed by her political ineptitude. Her slash and burn criticism of anyone who opposed the administration was hardly a way to build a consensus."

— **Business Insurance editorial**, on Hillary Rodham Clinton

"The more the states try to fix the system, the more they drive healthy people into the shelter of ERISA."

— **Mary Nell Lehnard, vice president, Blue Cross and Blue Shield Association**, New York Times

"I am so tired of that cynical approach that says that the only thing we're organized to do is protect doctors' pocketbooks that if I hear it one more time I'm going to throw up."

— **James Todd, MD, AMA executive vice president**

"In the nationwide health care debate, the single-payer plan has been like the bridesmaid who never gets to be a bride."

— **Sacramento Bee**

"This is a law that I will have to break because I'm not going to stop giving care to anybody."

— **Robert Karns, MD, president of the Los Angeles County Medical Association**, on California's Proposition 187, which calls for restriction of state services such as medical care for illegal immigrants, ABC World News Tonight

"Correctional medicine is becoming a respectable field. It's a lot of fun. The diseases are interesting, and the inmates are, by and large, decent people who have committed crimes but are not evil."

— **Stuart Shapiro, president and CEO of Prison Health Services**, on the privatization of correctional health care, Philadelphia Inquirer

"Talking about this is like talking about sex in public. Everybody knows how you reduce the deficit, but no one wants to talk about it in front of everybody else."

— **Congressional Budget Office Director Robert Reischauer**, about the need for budget cutting, Los Angeles Times

"It is tough to tell the truth in today's Washington. Since the politicians won't do it, any budget director worthy of her green eyeshade will just have to keep writing memos."

— **Baltimore Sun editorial** about a memo written by Office of Management and Budget Director Alice Rivlin regarding possible Medicare cuts

"American parents have a very free hand in giving over-the-counter drugs to their young children, even though many of the most popular children's remedies, especially cough and cold medications, may not work."

— **a U.S. Centers for Disease Control and Prevention study**, Journal of the American Medical Association



Carla Sommerfeld

LYNN SEIDENBERG, ISMIE professional liability specialist, is the most recent recipient of ISMS' Employee Recognition award. She manages all breast implant claims involving ISMIE policyholders and sits on ISMIE's Breast Implant Subcommittee.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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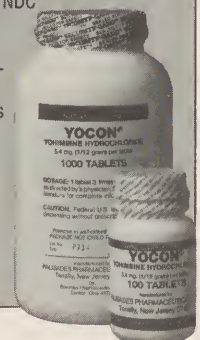
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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Doctor believes
in treating
patients
like friends

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ISMIE Update

Watch for the next
issue of Illinois
Medicine to see
how tort reform
supporters fared
in the general
election

MALPRACTICE ROUNDUP

Former Bush aide wins \$8.8 million judgment in Tylenol suit

A former White House official was awarded \$7.855 million in actual damages and \$1 million in punitive damages for liver damage allegedly caused by Tylenol, according to an Oct. 21 report in the New York Times. The plaintiff, a special assistant to President George Bush, was healthy until he took Tylenol Extra Strength pain reliever for flu symptoms, the article said. After taking the recommended dosage for several days, he lapsed into a coma and had to have a liver transplant. Currently, the patient is in danger of losing his kidneys because of a reaction to the medication he must take to prevent rejection of the liver, the article said.

Testimony revealed that the plaintiff regularly drank wine with dinner, which specialists said could create the potential for liver damage from usually harmless amounts of Tylenol, according to the story. Experts testifying for the plaintiff said Tylenol manufacturer McNeil Consumer Products Co. knew that liver damage could occur in people who drink alcohol and take ordinary doses of the pain reliever, but the company never warned the public. Last year, experts advised the U.S. Food and Drug Administration to place an alcohol warning on Tylenol labels — a recommendation that has not yet been implemented.

Johnson & Johnson, McNeil's parent company, claimed a pre-existing viral infection caused the patient's problems and said it will appeal the ruling, according to the article. ■

Plaintiff awarded \$600,000 in damages for misread AIDS test

A woman misdiagnosed with AIDS was awarded \$600,000 by a Florida circuit court, according to the Chicago Tribune. Because the plaintiff believed she was dying of AIDS, she gave custody of her three children to her mother and made plans to commit suicide if the disease incapacitated her, the story said.

But two years after she received the AIDS diagnosis, the plaintiff learned she was HIV negative through a retest performed by an AIDS hospice clinic in her hometown in Georgia. The woman subsequently sued Florida's Department of Health and Rehabilitative Services, which tested her original blood sample; the health clinic that drew the blood; and the physician who treated her.

In its ruling, the court cleared the clinic but found the state lab 65 percent responsible and the physician 35 percent responsible, according to the story. The jury said the Department of Health and Rehabilitative Services should pay \$390,000 of the \$600,000 award. Florida law, however, caps damages for state government agencies at \$100,000. Only the state legislature can alter the cap. The physician agreed to a pretrial settlement of \$250,000, which turned out to be \$40,000 more than he would have paid if he had gone to trial.

The department plans to challenge the ruling, as does the plaintiff, who believes the clinic should also have been found responsible, the article said. ■

Forum spotlights tort reform

PRESENTATION: Speakers share liability concerns at Civil Justice League meeting. BY KATHLEEN FURORÉ

[ROCKFORD] Representatives from the medical, business and nonprofit communities underscored the need for tort reform during an Oct. 20 Illinois Civil Justice League forum in Rockford. Moderated by league president Ed Murnane, the morning symposium was designed to show the public how soaring liability costs affect all Illinois citizens.

"Recent figures show the direct cost of tort liability was \$6.7 billion in 1992, which translates to \$600 per man, woman and child," Murnane said, citing statistics from a study conducted for the league by Northern Illinois University. "And that doesn't take into account such indirect costs as the higher prices we pay for medical care and groceries." When direct and indirect liability costs are combined, per-person estimates increase to the \$1,500-to-\$1,800 range, he added.

The Illinois Civil Justice League is a coalition of entrepreneurs, businesses, local governments,

associations, including ISMS, and nonprofit organizations that are working to achieve caps on noneconomic damages in civil cases in Illinois. The Rockford forum was part of an ongoing series of meetings the league has conducted around the state since late 1993 to heighten awareness about the need for tort reform.

Speakers at the Rockford forum, including ISMS President-elect Raymond Hoffmann, MD, shared stories and statistics illustrating what Dr. Hoffmann called a "legal system gone out of control."

"Right now, there are too many lawsuits of too little merit costing too much to defend," he added. "An AMA study estimates that professional liability costs account for fully 18 percent of the money Americans spend on physician services."

Dr. Hoffmann told the audience that the number of claims against ISMIE physician policyholders skyrocketed to 2,800 in 1993, up from 1,300 in 1986. In



Dr. Hoffmann

addition, the insurer incurred more than \$51 million in legal fees and other expenses to defend physicians against those claims, most of which were unfounded. "If we could redirect some of these vast sums into actual patient care for people in need, we could accomplish a large part of the goal of health system reform. How can we do it? Physicians firmly believe that while we need to preserve patients' ability to recover full economic damages, such as lost wages and medical expenses related to injury, we also need to impose a commonsense limit of

(Continued on page 7)

Nominations sought for ISMIE Board

ISMIE's Annual Meeting will be held on Wednesday, April 19, 1995, at the Oak Brook Hills Hotel and Resort. At the meeting, new members will be elected to the ISMIE Board of Governors. Board members are elected by a majority vote of policyholders represented at the Annual Meeting in person or by proxy.

The Board of Governors is composed of 21 members who are elected for staggered three-year terms. The Board, which meets four or five times a year, has general supervision over ISMIE's finances and operations. It also establishes all policies governing the transaction and conduct of the company's business.

Each Board member is appointed to serve on at least one of ISMIE's five committees: the Nominating Committee, the Policyholder Services Committee, the Planning Committee,

the Risk Management Committee and the Investment Committee. Committees meet several times a year and report regularly to the Board. Board members receive an honorarium and are reimbursed for actual expenses incurred for attending Board and committee meetings. They also represent ISMIE at meetings of hospital medical staffs, county medical societies, specialty societies, residency programs and other physician organizations.

In 1995, the terms of seven Board members will expire. Any ISMIE policyholder interested in serving on the Board should send a statement of interest and a curriculum vitae to ISMIE Board Chairman Harold L. Jensen, MD, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. Statements of interest should be no more than 250 words. They will be sent with the notice of Annual Meeting

and proxy to all ISMIE policyholders before the meeting.

Each candidacy must be seconded in writing by two ISMIE physician insureds. Individual policyholders may second nominations for up to seven candidates. Nominations and written nomination seconds must be received at ISMIE offices by Jan. 2, 1995.

All candidate submissions are reviewed by the ISMIE Nominating Committee, which compiles a slate of recommended nominees. Careful consideration is given to qualified nominees. The committee attempts to ensure broad representation of all policyholders based on geography, insurance class and specialty.

Candidates who are not included on the recommended slate will be notified and may ask to be placed on the ballot as independent candidates. Policyholders may vote for the recommended slate, independent candidates or a combination. ■

My patient, my friend

By Eugene McEnery, MD

It has always impressed me that friends seldom find cause to bring lawsuits against one another. I think that fact has important application to the practice of medicine. Based on more than 30 years of practice experience, I suggest that taking the time to befriend your patients is a valuable investment, not only as a means of enhancing the care you offer your patients but as a way to avoid lawsuits.

Too often, in the rush of a busy day, we forget that our patients come to us with a combination of physical and emotional needs. We see the physical ailments, but we fail to recognize and acknowledge the accompanying psychological fears or mental trauma.

By viewing patients as friends, we recognize those needs. Offer the time it takes to listen to what they have to say, ask them a few light-hearted questions about themselves, present a more understanding attitude and let them know that you don't always have the right answers.

Doesn't taking a few minutes to ask some disarming questions and "deformalize" the atmosphere put the patient at ease and make our job easier and more enjoyable? I am always amazed at how quickly this approach turns a

patient into a friend, regardless of whether I'm in the hospital or my office.

No one practicing medicine can avoid an occasional angry patient who has medical problems that won't improve or legitimate complaints about past associations with hospitals, doctors or the medical profession. Attempting to befriend such patients may or may not keep you off their "bad guy" list, but it surely can't hurt.

Our friends in the legal profession who share our concern about the avalanche

of malpractice suits are, after all, constantly reminding us of the need to communicate more with patients and to develop with them more personal one-on-one relationships.

I encourage you to become your patients' friend. Do not criticize. Show empathy and understanding. Be the friend you would want to have if you were sick, frightened, unsure or angry. In response, your patients should be far more ready to understand and tolerate your weaknesses and perhaps even forgive your human failings.

I have no patience for physicians who will not admit personal error or who place personal gain above medical cor-

rectness. But I — and your patients — will more likely excuse physicians who are openly caring and honest.

Remember, too, that whether you win or lose on the legal front, it is not insignificant that you are friends with your patients. We live in a jaded society that distrusts doctors and is often swayed by biased medical news reporting in the lay press. Your efforts will demonstrate that doctors are human, caring and, above all, individuals to be trusted.

So, make a friend of your patients and avoid a lawsuit. ■

Dr. McEnery is a urologist in Chicago. He is also an ISMS member.

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\$250,000 on noneconomic damage awards for intangible reasons such as pain and suffering."

Lawsuit abuse is affecting access to care and is beginning to limit the kind of care available. An ISMS medical malpractice survey showed that more than half of the physician respondents had stopped performing risky procedures and 39 percent had limited the use of new techniques, Dr. Hoffmann said.

Health care companies are also affected by increasing liability. For example, because of judgments Dow Corning expects to pay for silicone breast implant suits, the company may stop making silicone, which is used in catheters and pacemakers, he said.

The effect of burgeoning liability on businesses and the public is serious, according to other speakers at the program. For example, the Chicago Park District lost a multimillion-dollar lawsuit to the mother of a toddler who was disabled after falling off the platform of a slide, said Jim Grove, executive director of the Oregon Park District. "That is not only one of the reasons taxes are so high, but also why some park districts limit or don't have programs."

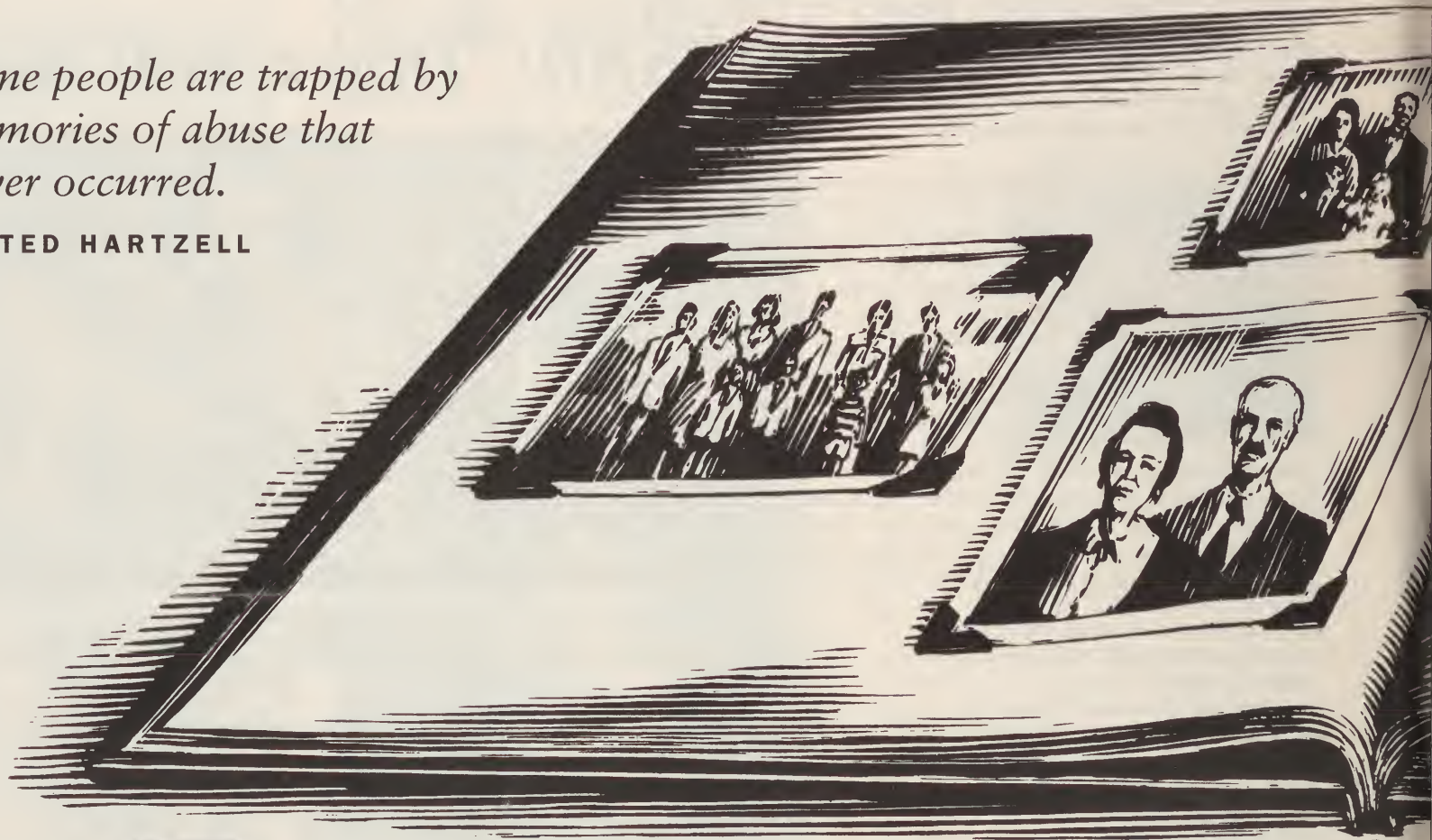
Many businesses are moving from Illinois to southern Wisconsin because Illinois' workers' compensation insurance premiums have increased an average of 10 percent a year, due, in part, to liability costs, said Brent Johnson, vice president of Ringland-Johnson Construction in Rockford.

Municipalities are also feeling the effect of litigation, Murnane said, noting that more than \$1 million of Arlington Heights' \$21-million municipal budget is spent on liability costs instead of on the police and fire departments and other community services. ■

Helping patients escape the

Some people are trapped by memories of abuse that never occurred.

BY TED HARTZELL



The memories bobbing up from her childhood were terrible – so terrible that the woman, now middle-aged, couldn't really believe them herself. But the memories persisted of being chained to a bed and raped and being punished for getting blood on the sheets.

The woman's therapist decided on a gentle, non-prodding approach to treat her. "For a year, we pretty much stayed in a state of limbo as far as memory was concerned," said Tom Ryan, the director of the Childhood Trauma Treatment Program in Bolingbrook, part of the EHS Family Care Network.

A breakthrough occurred when the patient invited her family to a therapy session. Event by event, they substantiated her horrible recollections. "It was a wonderful confirmation for her," Ryan said.

But not all cases of childhood trauma – sometimes supposedly recalled decades later – can be substantiated. And recently, proving such allegations has been complicated by a phenomenon called false memory syndrome. An increasing number of cases have been documented in which individuals who said they remembered being abused as children later recanted

their allegations, saying they were misled by their therapists into accusing their parents of decades-old incidents of incest.

False memory syndrome is a "condition in which a person's identity and interpersonal relationships are centered around a memory of traumatic experience [that] is objectively false but in which the person strongly believes," according to University of Arizona psychology professor John Kihlstrom, who is associated with the Philadelphia-based False Memory Syndrome Foundation. Its Scientific and Professional Advisory Board is composed mostly of psychiatrists and psychologists.

False memory syndrome is a popular term and doesn't describe a medically recognized syndrome. But it does help describe therapist-patient relationships that inappropriately turn on an interaction in which patients, wanting to please their therapists, "remember something they're supposed to," said Peter Fink, MD, an associate professor of psychiatry and pediatrics at Rush-Presbyterian-St. Luke's Medical Center, who consults on cases referred to him by other mental health professionals.

Like all people, individuals with deep psychological

SYNDROME

oast



Bob Dahm

problems are “looking for answers,” Dr. Fink explained. “People are always looking for reasons why they don’t feel good,” but sometimes in therapy they are swayed by counselors who are too narrowly focused.

Besides the universal human trait of seeking reasons for psychological problems, there is a more powerful force at work within the therapist-patient relationship: the need to connect. That pull is so powerful that it can cause patients to discard facts and provide answers they think their therapists want to hear, Dr. Fink said. In this way, patients fill the compelling need to stay connected.

“The syndrome may be diagnosed when the memory is so deeply ingrained that it orients the individual’s entire personality and lifestyle, in turn disrupting all sorts of other adaptive behaviors,” Kihlstrom said. “False memory syndrome is especially destructive because the person assiduously avoids confrontation with any evidence that might challenge the memory. Thus it takes on a life of its own, encapsulated and resistant to correction.”

As of February 1994, the False Memory Syndrome Foundation said it had documented more than 13,000

possible cases of false memory syndrome. An April 1993 demographic study of affected families showed that 92 percent of the accusers were female and 26 percent remembered abuse that had occurred before they were 2 years old. Eighteen percent of those accused were alleged to have participated in ritualistic, satanic abuse.

Some people question whether valid cases of repressed abuse memories are as widespread as they might seem. In addition, they point to the unnecessary harm that may be inflicted on older parents, frequently in their 70s, when an adult child claims to have recalled unsubstantiated instances of sexual abuse. And because of cases involving questionable assertions of abuse, real victims may not be believed as readily.

In some cases, therapists eager to detect signs of sexual abuse in their adult patients are, indeed, finding those signs. Those therapists are suspected of playing out their biases by hinting to their patients – or even informing them outright – that their current problems were caused by sexual abuse they suffered as children.

In extreme cases, “memories” are sometimes induced by so-called recovered-memory techniques

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False memory syndrome

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like hypnosis, sodium amytal and free-association writing, techniques that may be used by poorly trained therapists.

In a report released this summer, the AMA's Council on Scientific Affairs criticized the use of hypnosis to uncover memories of child abuse. The report reaffirmed AMA policy adopted in 1984, stating that hypnosis should be limited to the investigative process. Memories induced by hypnosis appear to be less reliable than nonhypnotically recalled memories, the report said. In addition, a review of amytal concludes, "It has no legitimate use in recovered-memory cases."

"The AMA considers recovered memories of childhood sexual abuse to be of uncertain authenticity, which should be subject to external verification. The use of recovered memories is fraught with problems of potential misapplication."

SINCE THE 1860S, societal concern about child abuse has surfaced in roughly 25-year cycles, Ryan said. The Childhood Trauma Treatment Program was established in 1976, a year in which only 67 cases of child sexual abuse were reported in Illinois. "We started with three clients and thought we'd never see any more than that." The program now handles about 275 patients at any given time.

Such programs were fueled by the women's movement, which called attention to rape and, by extension, various kinds of sexual abuse or "what they called rape of children," Ryan said.

There have been distinct patterns in the rise of sexual abuse allegations, he said. "It began [in the 1970s] with a sense that we had all trapped children by refusing to either see it or believe it. So, suddenly everybody was asking if a child had been sexually abused." Childhood sexual abuse was assumed from such occurrences as flashbacks, nightmares and self-mutilation. "When the therapy community took on sexual abuse as an explanation, [it] took it on with a vengeance."

Many therapists were cautious not to "put information where it didn't belong," but others who were not so cautious led their patients to wrongly believe they had been sexually abused as children, Ryan explained.

THE SEARCH FOR the truth about past trauma has led accusers and the targets of their allegations to seek redress in court. In 1990, a California jury found George Franklin guilty of murdering an 8-year-old girl 21 years earlier. The girl was a playmate of Franklin's daughter, whose testimony was crucial to the conviction. The daughter testified that she had repressed memories of the murder for two decades.

If the outcome of the Franklin case supports the theory that painful memories can be repressed, the outcome of a more recent California trial demonstrates that repressed memories are not always valid. Last May, Gary Ramona, a 50-year-old former winery executive, was awarded \$500,000 by a jury in a civil case in which he claimed that a social worker and a psychiatrist had

conned his daughter, Holly, into recalling that he had molested her for years when she was a child.

Even people who question the validity of repressed memories emphasize that sexual abuse of children is real and deplorable and can have devastating consequences. But they contend that, as in the case of Holly Ramona, some adult patients who say they remember childhood sexual abuse are remembering events that never actually happened.

When the therapy community took on sexual abuse as an explanation, it took it on with a vengeance.

Unfounded allegations of sexual abuse are also becoming increasingly common in contentious custody fights between divorcing parents, Ryan said.

"The biggest worry we have now is there's a reward in [making such accusations]," noted Domeena Renshaw, MD, a psychiatrist affiliated with the Loyola University Stritch School of Medicine. Winning a civil suit based on accusations of long-ago abuse is "like getting your inheritance early."

As an example of how false accusations become part of custody battles, Dr. Renshaw cited a case in which she examined two children, ages 6 and 8, at the request of their father. A counselor in Ohio's child-welfare system was supposed to take an objective history from the children but instead allegedly used a tape recording in an attempt to coach them into believing their father had molested them.

It didn't work, though. "I interviewed each child, and they roundly denied that their father had done anything of the sort," Dr. Renshaw said. The sad thing is, there are some counselors, untrained in this area except for a few seminars, who stake their reputation and advancement on trying to prove every allegation is true, she added. "Not every one is true. Truth and lies are very difficult to determine in

clinical medicine."

Objective therapists do not impose a symptom on patients. Instead, "You ask and you ask and you ask," Dr. Renshaw explained.

Such persistence is necessary when dealing in an area as elusive and malleable as memory, Dr. Fink added. "Memory is not a photograph, not a CD, not etched in stone. You're constantly constructing reality from bits and pieces between your ears, and that reality is constantly influenced by what's coming in."

There are at least four kinds of memory, according to Lenore Terr, MD, a San Francisco psychiatrist and a national authority on childhood trauma and memory. They are wholly true memory with true details, true memory with false details, wholly false memory with false details and false memory with true details gleaned from outside influences such as television programs or the news media.

Intuitive logic suggests that people who suffer through terrible events over a long period will remember them, Dr. Terr said. But in reality the opposite can occur. Victims can forget parts of events or entire episodes, because their mental "defenses kick in."

Memory research has shown the distinction between explicit and implicit memories, Dr. Terr said. Explicit, or declarative, memory refers to conscious recall of facts or events, according to a December 1993 American Psychiatric Association statement on the memories of sexual abuse. Implicit, or procedural, memory refers to behavior that exhibits knowledge of an experience but without conscious recall. For example, a child who knows how to ride a bike but can't remember actually learning that skill is demonstrating implicit memory.

"There is no completely accurate way of determining the validity of [allegations of long-ago childhood sexual abuse] in the absence of corroborating information," the statement said. Therefore, psychiatric treatment may entail helping patients adapt to the uncertainty of situations in which memories are unclear and there is no corroborating evidence.

"It is not known what proportion of adults who report memories of sexual abuse were actually abused," the report added. "Psychiatrists should maintain an empathic, nonjudgmental, neutral stance toward reported memories." ■

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Child abuse widespread

By Ted Hartzell

No one involved in the controversy surrounding false memory syndrome doubts that child abuse is a deeply rooted problem in the United States.

In 1992, nearly 2.9 million children were reported to have been the victims of maltreatment, according to a publication of the U.S. Department of Health and Human Services. The allegations were substantiated or indicated in about 34 percent, or almost 993,000, of those cases.

In Illinois that year, there were 131,592 reports of maltreatment of children. The reports were substantiated in 33 percent, or 43,433, of those cases.

Maltreatment was defined by the

publication as neglect, physical abuse, sexual abuse, medical neglect and emotional or psychological abuse. In the 49 jurisdictions that reported abuse cases and that used those categories in their reports, neglect was the most common form of abuse. It was reported in 49 percent of the cases. Sexual abuse accounted for 14 percent of substantiated cases.

The problem of child abuse is far greater than it was just two decades ago, according to official reports. In 1976, an estimated 10 children per 1,000 were reported as victims of maltreatment, according to a comparison of unsubstantiated reports cited in the HHS publication. By 1992, that number had increased to 43 children per 1,000. ■

Republican control

(Continued from page 1)

"These changes are good news for Illinois patients and physicians because tort reform will receive a full airing in the new legislature," he continued. "We look forward to working with legislators of both parties to advance caps and many other priority issues. Over the next several weeks, ISMS will be developing a strategy for approaching the next legislative session."

"This was a major victory for proponents of tort reform," said Edgar spokesperson Mike Lawrence. "It's clear that meaningful tort reform will have the

best chance in decades of being approved by the General Assembly now that Republicans control the House and the Senate."

Republicans defeated 12 incumbent House members and gained one open seat, resulting in a 64-54 majority. In the Senate, Republicans added one seat to their majority.

In the Republican sweep of statewide races, winners were Bob Kustra over Penny Severns for lieutenant governor, Jim Ryan over plaintiff attorney Al Hofeld for attorney general, George Ryan over Pat Quinn for secretary of state, Loleta Didrickson over Earlean Collins for comptroller, and Judy Baar



Jim Ryan

Topinka over Nancy Drew Sheehan for treasurer. In the 29th Illinois Senate District (north suburban Chicago), Republican Kathleen Parker won a hard-fought battle over Grace Mary Stern, the Democratic incumbent. In the 100th House District (Springfield), Republican Gwenn Klingler, an ISMS Alliance member, defeated Marylou Lowder Kent, former Illinois State Bar Association lobbyist.

Nationwide, the GOP picked up the

necessary seats to take control of both houses of Congress from the Democrats. In two key Illinois races for open congressional seats, Republican Jerry Weller beat Frank Giglio in the 11th District (south and southwest suburbs and collar counties), and Republican Ray LaHood bested Douglas Stephens in the 18th District (Peoria and the surrounding area). The results mark the first time since 1954 that a political party has lost both houses in one election.

For an in-depth analysis of election results and their impact on physicians, watch for continuing coverage in Illinois Medicine. ■

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Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Immunization program

(Continued from page 1)

surest way to offer them an opportunity at a life free from the effects of serious, yet preventable, diseases."

The state program expands on the federally funded and state-operated Vaccines for Children program, which has experienced implementation problems in other states but has operated in Illinois since Oct. 1, said an IDPH spokesperson. The federal program guarantees that private health care providers can receive free vaccines to immunize children who are enrolled in Medicaid, who lack health insurance or who are of American Indian or native Alaskan descent. But under the federal program, children whose health insurance doesn't cover immunizations can receive free vaccines only at federally qualified and rural health centers.

Illinois' new program allows underinsured children to receive free vaccines from any private provider who is enrolled, according to IDPH. VFC Plus corresponds to ISMS policy, which calls for the Society to work with IDPH to provide immunization materials at no cost to all practicing physicians who treat children.

"The department and state provider associations recognize that the referral of underinsured children to federally qualified health centers or rural health clinics would fragment the health care of these children," explained IDPH Director John Lumpkin, MD. "The Illinois Vaccines for Children Plus program eliminates the need for private providers to refer their underinsured patients elsewhere. It maintains medical services in a single location and thereby keeps these children in their primary medical homes."

IDPH estimates that the state program will provide 615,000 annual doses of vaccine that would not have been available for administration under the parameters of the federal program alone. The cost of those additional vaccines is \$5 million a year. Overall, \$21.8 million in federal and state funds will be used to purchase and deliver vaccines to providers in Illinois during the program's first year of operation, according to the department.

The program's success depends on

Results of IDPH immunization survey announced

BY KATHLEEN FUREORE

The Illinois Department of Public Health recently released results of a survey it conducted in October 1993 in conjunction with Adult Immunization Awareness Week. The survey was mailed to 3,025 pediatricians, family practitioners and general practice physicians Downstate to assess their attitudes and practices regarding adult immunization for influenza, pneumococcal pneumonia, and tetanus and diphtheria. The survey was also intended to raise physician awareness about the need to identify adult patients at risk of contracting diseases that are preventable through immunization, an IDPH spokesperson said.

Of those surveyed, 13 percent, or 392 physicians, responded to the questionnaire. Physicians were asked whether they routinely recommend vaccines for adults, why they think patients refuse vaccines and what they consider the most effective ways to increase public awareness about the need for adult immunization.

The survey revealed that 95.4 percent of respondents administer the influenza vaccine, 89.5 percent provide the pneumococcal vaccine, and 87.5 percent give the tetanus-diphtheria toxoid to their adult patients.

Due to patients' concerns about reactions or illness, 9.4 percent of respondents don't routinely recommend the

flu vaccine for high-risk patients. And 9.2 percent said they don't recommend the pneumococcal vaccine because they don't keep it on hand. Some respondents said they don't recommend the vaccines regularly because of questions about their efficacy or safety or due to

• 95.4 percent of respondents administer the influenza vaccine

• 89.5 percent provide the pneumococcal vaccine

• 87.5 percent give the tetanus-diphtheria toxoid

uncertainty about the target group that should receive them.

The flu vaccine is recommended to high-risk patients by 96.4 percent of respondents, and 92.6 percent provide patients with information about the importance of immunization. Seventy-four percent of respondents said they believe patients most commonly refuse the flu vaccine because they have experienced a bad reaction.

Most of the physicians who responded to the survey said the most effective vehicles for raising public awareness about the importance of flu and pneumococcal immunizations are television (90.8 percent), newspapers (71.2 percent) and radio (69.4 percent). But only 10.7 percent send reminder cards about annual flu shots to high-risk patients, and just 21.8 percent tag the charts of high-risk patients so they can offer the flu vaccine at a later office visit.

IDPH will share the survey results with the statewide Immunization Advisory Committee to help develop a campaign promoting adult immunizations. In addition, the department's immunization section will conduct a similar survey before year's end to compare physicians' current practices and attitudes with those from 1993, the spokesperson said.

As IDPH released its survey results, the Chicago Sun-Times reported an announcement by the U.S. Centers for Disease Control and Prevention that too few elderly people are receiving flu shots. A survey of state and local health departments found that many people don't know Medicare began covering flu shots last year. In addition, it showed that some older adults hesitate to be immunized because of concern about billing and claims procedures. A national goal is to immunize 60 percent of high-risk groups against influenza annually, the article said. ■

physician participation, IDPH said. As of Oct. 28, only 100 physicians had responded to an enrollment packet mailed to private providers who care for children 18 and under, the department spokesperson said. "To reduce fragmentation of health care services, we need the widespread support of private physicians and health care providers," Dr. Lumpkin said. "We would strongly encourage them to enroll in this critical program."

Participating physicians can save their patients as much as \$270 by providing

the free vaccines, the IDPH spokesperson said. Although physicians cannot charge for the vaccines, they can accept payment of administration fees and office visit charges, he added.

Physicians who participate in Medicaid should also enroll in the VFC Plus program, since the current vaccine replacement program administered through Illinois' Medicaid program will be eliminated when VFC Plus is fully operational, Dr. Lumpkin said.

The expanded state vaccine program will help pediatricians provide the care

and services children need most, said Mark Rosenberg, MD, chairman of the governmental affairs committee of the Illinois chapter of the American Academy of Pediatrics. "Immunization is the keystone of preventive care. We're seeing more and more people going to clinics, and this provides vaccines at no cost right in the physician's office. It also will help achieve the goal of immunizing 90 percent of 2-year-olds at the appropriate age."

For information about enrolling in the program, physicians may call (800) 526-4372. ■

Domestic violence

(Continued from page 1)

continue to grow." About 300,000 Illinois women become victims of domestic violence annually, he noted.

The guidelines, which deal with males who abuse females, have been distributed to more than 200 groups and individuals, including physicians, hospitals, police departments, attorneys, members of the clergy and social service agencies, according to an IDPA spokesperson. They are intended to help those who work with batterers to teach abusers how to handle immediate conflicts without abusive behavior, said IDPA Director Robert Wright. By identifying treatment programs that meet state standards, the guidelines will also assist agencies and individuals who refer abusers for treatment. IDPA is required by law to fund and administer services for domestic violence victims.

"Batterer services are essential because they help abusers acknowledge their abuse, understand why they do it, accept

responsibility for its impact and learn new ways to change their actions," Wright explained.

The guidelines recommend that treatment of abusive men should challenge their belief that they have a right to

To treat the entire problem of domestic violence, we have to identify and help those with a high risk of abusing.

control women and that aggression is a legitimate way to resolve conflict. They also state that treatment programs should promote respect for women, empathy for abuse victims and an understanding of the negative effects

the abuse has caused for the victims and their families. In addition, programs should require abusers to sign contracts in which they acknowledge their violent patterns of behavior and pledge to follow program rules to stem their abusive behavior.

The guidelines also address the forms of abuse. For example, the definition of abuse of women states that physical abuse is usually accompanied by other controlling behaviors, such as threats, sexual abuse, emotional abuse, economic abuse, the manipulative use of children, isolation and coercive enforcement of sex role stereotypes.

Physicians should help identify instances of domestic violence and assist victims and abusers in dealing with the problem, said Eric Bleyer, MD, a member of the Domestic Violence Council and an assistant professor in the internal medicine and pediatrics department at Southern Illinois University. "Often, we're the initial contacts for [people with] these problems. They don't know whom to turn to except the local physician."

To help stem the rise of domestic violence, ISMS and the Alliance launched their Anti-Violence Initiative in the fall of 1993. The ongoing program is designed to help physicians identify the signs of abuse and provide them with educational materials, including lists of shelters for abuse victims and county, state and national agencies dealing with abuse.

Although protecting abuse victims is a priority, treating abusers is a notable step in preventing domestic violence, Dr. Bleyer said. "It's like a heart attack. The first step is to stop the attack, the next step is to look at ways to prevent it from happening again. Certainly, we have to look at the bigger picture. To treat the entire problem of domestic violence, we have to identify and help those with a high risk of abusing."

For a copy of the state guidelines, physicians may call IDPA during regular business hours at (217) 524-6034. To obtain an informational kit from ISMS and the Alliance, members may call (800) 782-ISMS or (312) 782-1654, ext. 1241. ■

Send ad copy with payment to Sean McMahan, Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602; (312) 782-1654, (800) 782-ISMS; fax (312) 782-2023. Illinois Medicine will be published every other Tuesday; ad deadlines are four weeks prior to the issue requested. Although the Illinois State Medical Society believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify advertisements at its discretion.

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Selling a practice

(Continued from page 1)

Physicians should also look for "hidden liabilities" before trying to sell, said Love, who is president of Chicago-based Professional Management Associates Midwest Ltd. To figure the worth of a practice, she looks at the medical records and the managed care plans in which the physician participates. A large number of rejected claims and contractual agreements that are unfavorable to physicians could be considered a liability, she said. "If you have rejections of 25 percent, you're an audit waiting to happen. And if you're in a managed care contract that holds the buyer harmless [for the cost of defense and judgment against the plan] or has no stop-loss insurance [to protect from unlimited losses associated with catastrophic cases], it poses a tremendous liability."

Because of these factors, physicians should review and fully understand all of their managed care contracts, Love noted. "One contract I saw said the plan had the right to cancel the physician with a 10-day notice but that the physician was still obligated to treat his patients until their medical problems were resolved, even though he couldn't bill the patients." There would be a big difference between treating a patient with appendicitis and one with a long-term illness. If the physician had to absorb the cost of treating a patient who required treatment for several years, it could bankrupt the practice, she said.

Love recommended canceling participation in such physician-unfriendly plans before placing a practice on the selling block. In addition, practices in managed care are usually more valuable than those that are primarily fee for service, because patients are locked into the practices and the plans, she said.

Physicians should get a practice appraisal by an independent third party instead of relying on the prospective buyer's valuation, the consultants advised. "Sometimes physicians trust in the hospital, but they need their own agents speaking for them," said Henderson-Damon. "Hundreds of thousands of dollars are at stake, so it's worth investing in a practice valuation before trying to sell."

COMPENSATION IS ANOTHER area physicians should examine closely before signing a contract with the purchasing entity, Gallagher said. Typically, a buyer will offer a salary as high or higher than what the physician is making in his or her own practice. But those initial numbers can be deceiving, she warned. "Usually, there is a provision that compensation becomes incentive-based and can be decreased over time. An Ob/Gyn netting \$300,000 might sell to a hospital system for assets plus a guaranteed salary of \$300,000 per year for the first two years of employment. But then a different arrangement kicks in."

Gallagher explained that physicians who are employed by hospitals that have entered into capitation contracts could see their incomes drop dramatically after the initial employment period. "Under capitation, a physician's salary will be based on the employing entity's profits. So if the practice is not as profitable under capitation, a physician's salary will decrease accordingly."

Before deciding whether the compensation offered is as good as it seems, physicians must take into account all

their business write-offs, Henderson-Damon added. "You don't want your salary to go down when you sell your practice. When you own your own practice, you're probably writing off things like your car and continuing education. That's all part of your salary. What it says on your W-2 does not necessarily represent your total compensation."

In addition, doctors should consider how their departure or termination from the hospital or insurance company would affect their future ability to practice medicine. Most employment agreements contain restrictive covenants prohibiting physicians from keeping their patients and from practicing within a

specified geographic area if they are no longer working for that hospital or insurer. "Suppose your income has decreased dramatically and you decide to affiliate with someone else. If there's a restrictive covenant, you'll have to leave your patient base," Gallagher explained.

As an example, she cited the case of a physician who was offered a contract that contained a restrictive covenant and allowed the hospital to terminate him without cause. "Physicians could be getting much better deals, but they don't have adequate legal representation."

Although purchase agreements without some type of restrictive covenant are unusual, physicians do have some lee-

way in negotiating those contracts, Gallagher said. "You can try to make the restrictive covenant null and void if there are any breeches in the purchase or employment agreements. And you also could whittle down the geographic area or period of time it affects."

ISMS members seeking the services of an attorney who specializes in health care contract issues can receive an immediate referral through ISMS' Lawyer Referral Network. To access the network, physicians may call (800) MD-ASIST. Members will also be able to obtain referrals for health care consultants through ISMS' consultant referral service, which will be operational soon. ■



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Progress made
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Election results increase chances for caps

TORT REFORM: Legislative victories bring good news for Illinois physicians.

[CHICAGO] The takeover of the Illinois House by tort reform supporters in the Nov. 8 general election has increased the chances of achieving caps in Illinois. Gov. Jim Edgar's decisive win over Dawn Clark Netsch and the successes of tort reform proponents in key House and Senate races represent victories for ISMS and Illinois physicians. Those wins give tort reform legislation the best chance of passing it's had in years.

A cap on noneconomic damages in civil suits, including medical malpractice cases, stood little chance of being enacted if Netsch had won the governor's race — even with the Republican majority in the General Assembly. Although tort reform is considered a bipartisan issue, Democratic House Speaker Michael Madi-

gan had blocked all efforts to reform tort law. In fact, from July 1 through Oct. 9, plaintiff attorneys contributed more than \$1 million to Madigan to help him maintain his stronghold on the House. Plaintiff attorneys worked hard on Madigan's campaign, and their individual contributions in addition to those from the three-month period are also believed to have been substantial.

Although intensive lobbying will still be necessary to educate legislators about the need for tort reform, the issue is expected to receive a full hearing with a 64-54 GOP majority in the House and Rep. Lee Daniels (R-Addison) having been voted as speaker of the House.

Candidates who support physician issues swept the statewide races for constitutional posts. In the attorney gener-

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ELECTION



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Matt Ferguson

GOV. JIM EDGAR and first lady Brenda Edgar celebrate his victory on election night. Edgar, who won a second term Nov. 8, supports many physician issues, including caps on noneconomic damages in medical malpractice suits.

ISMS provides input on specifics of Medicaid plan

STATUS: The Society is urging IDPA to develop a reform program that improves care for recipients.

BY KATHLEEN FURORE

[CHICAGO] Although no final decisions about specific components of Illinois' Medicaid reform program have yet been reached, physicians should begin discussing the impact of the new MediPlan Plus program with their Medicaid patients, according to John Schneider, MD, ISMS Third District trustee and chairman of the Society's Third Party Payment Processes Committee.

"Members of ISMS are meeting on an ongoing basis with IDPA to press for a program that will provide better health care to Medicaid recipients," Dr. Schneider said. "We won't commit to any plan that doesn't protect the physician-patient relationship and that won't assure improved quality of care for Medicaid patients."

"The major thing physicians need to be doing now is communicating to their Medicaid patients that there will be a change in the way most Medicaid patients select their physicians," he continued. If physicians are interested in becoming

fee-for-service gatekeepers, they should tell their patients that they want to continue to treat them and that patients will have to choose them specifically when IDPA sends the enrollment forms. Physicians may encourage patients who want to continue with them to bring in enrollment forms to ensure that the information is marked appropriately, Dr. Schneider said.

Under the legislation creating MediPlan Plus, which was backed by Gov. Jim Edgar and passed by the General Assembly in July, 1.1 million Illinois Medicaid recipients will ultimately be shifted into managed care plans. Recipients will be able to select a capitated HMO, a capitated managed care community network, a federally qualified health center, a rural health center or a fee-for-service gatekeeper. Medicaid recipients who don't choose a primary care provider from among those options will be "defaulted" to one of the capitated systems.

(Continued on page 15)

HMOs look for 'high-quality' physicians

PROGRAM: Speakers reiterate the need for primary care doctors in managed care organizations. BY JANICE ROSENBERG

[OAK BROOK] Administrators of managed care organizations around the country are focused on recruiting primary care physicians who can deliver quality, cost-effective care, according to a speaker at a Nov. 2 panel discussion during the fall conference of the Illinois Association of Health Maintenance Organizations. In fact, recruitment of high-quality physicians is at the heart of any health care organization's mission, said panel member Nelson Tilden, PhD, president of the MedicalSearch Institute in Overland Park, Kan.

"It is generally easier to recruit physicians into a managed care environment, because it is a more structured environment, and that is very much what physicians are looking for these days," Tilden said.

MANAGED CARE

Calling competence a given, he explained that today's physician recruiters are looking for more. He described the "new, more desirable" physician as a team player with good communication skills and a caring attitude. To fit into a managed care environment, physicians must embrace an outcomes orientation, he told the audience of managed care providers and administrators.

For their part, young physicians are looking for shorter work weeks, predictable schedules and set or minimized call responsibilities, Tilden noted. "They're not lazy. They've simply given up the view of medicine as a profession requiring total dedication with no outside life."

(Continued on page 14)

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JENNIFER PAGE, MD (right), a rehab medicine resident, and Lawrence Tseng, MD, an anesthesiology resident, offer tips to medical students about interviewing for residency programs. The panel discussion was sponsored by the ISMS Medical Student Section and was part of a daylong program about preparing for the interview process.



Wm. Daniels/The Photo Partners

AMA opens retail outlet

[CHICAGO] The AMA is testing the retail waters with the Oct. 14 grand opening of its Family Health Products Center in Younkers department store in Milwaukee. Proceeds from the health- and safety-related merchandise sold in the shop will go to the AMA Physicians' Campaign Against Family Violence, a program that helps doctors intervene and treat domestic violence victims, according to an AMA spokesperson.

"This is a whole new realm for the AMA," said Timothy Flaherty, MD, an AMA trustee and a radiologist from Neenah, Wis. "It's part of an initiative to find new ways to support our public health programs."

The Family Health Products Center stocks about 125 items including blood pressure and pulse monitors. In addition, a video of American Medical Television's "Living Well America" program, which features health and lifestyle information, is shown in the store.

"This shop raises awareness about health care products and makes them more convenient and readily available to our customers," said Tom Gould, Younkers chairman and CEO. "We are pleased to be a part of this joint venture, especially when the proceeds benefit the Campaign Against Family Violence."

The AMA will monitor the store's performance for four months before deciding whether to venture into other markets, the spokesperson said. ■

Cook County and Rush form academic affiliation

[CHICAGO] Cook County Hospital and Rush-Presbyterian-St. Luke's Medical Center have formed an academic partnership that will combine the expertise of nearly 3,000 teaching physicians and affect more than 1,600 residents and medical students. The affiliation will capitalize on the academic and clinical strengths of the two hospitals to enhance the training of residents and students at both institutions, said Erich Brueschke, MD, dean of Rush Medical College.

"Wherever possible, programs at the two institutions will become integrated, with training occurring at both hospitals but under one academic framework. Our medical students and resident physicians will benefit immensely by completing rotations at one of the nation's largest public hospitals," Dr. Brueschke said.

As a result of the affiliation, physicians at Cook County Hospital will be granted faculty appointments at Rush, and Rush physicians will participate in educational activities at Cook County, according to a Cook County Hospital spokesperson. Members of both medical staffs will serve on institutional committees and will help establish a common educational direction, the spokesperson said.

"This is a major step in assuring the continued prominence of our two institutions in the provision of care and in the training of the medical providers of the future," said Cook County Board President Richard Phelan.

"The affiliation will enable Cook County and Rush to better face the coming changes in medical education and in the provision of patient care," noted Ruth Rothstein, chief of the county's Bureau of Health Services.

The Cook County-Rush affiliation builds on an almost century-old relationship, said Leo Henikoff, MD, Rush pres-

ident and CEO. Five years after the great Chicago fire, Rush rebuilt its medical school on the West Side to be next to the then-new Cook County Hospital, Dr. Henikoff added.

During the past year, Cook County Hospital and Rush also integrated their infectious disease programs. In addition, Rush's general surgery residents began rotations at Cook County on July 1. ■

Progress made on new information network

CHIN: Decisions regarding implementation are now being made.

BY JANICE ROSENBERG

[CHICAGO] With the appointment of 14 board members and the launch of negotiations with the vendor finalist, developers of the Metro Chicago Community Health Information Network have taken additional steps toward making the system a reality. The CHIN, which is co-owned and governed by ISMS and the Metropolitan Chicago Healthcare Council, will be the largest and most comprehensive network of its kind in the United States.

CHINs are computer networks that allow all segments of the health care industry to communicate with one another. In these networks, integrated computers form electronic links between hospitals, physicians, payers, employers, laboratories, pharmacies and other parties. CHINs are intended to reduce costs by reducing paperwork and administrative inconveniences and facilitating communication among health care providers through a rapid exchange of clinical and financial information.

ISMS and MCHC each named seven members to the CHIN board. Six additional board members representing the payer community will be appointed jointly by the two organizations as implementation of the CHIN continues. For the board to conduct business, however, only the 14 board members from ISMS and MCHC need to be in place. In selecting their board representatives, the two organizations sought diverse individuals who can help manage the philosophical, technical, marketing and practical challenges

that could be posed by the CHIN, according to a Nov. 12 ISMS Executive Committee report to the Board of Trustees.

ISMS appointees, which represent the Society and ISMIE, were ratified Nov. 12 by the ISMS Board of Trustees. They are Ronald G. Welch, MD, ISMS board chairman; Harold L. Jensen, MD, ISMIE board chairman; Alfred J. Clementi, MD, ISMIS board chairman; M. LeRoy Sprang, MD, ISMS secretary-treasurer; Alexander R. Lerner, ISMS executive vice president; Jeffrey M. Holden, ISMS chief operating officer; and Andrew Melcher, PhD, director of ISMS' health policy research department.

MCHC's seven representatives are Lawrence Haspel, DO, MCHC board chairman; Earl Bird, MCHC president; John Graham, MCHC board member; Joseph Toomey, MCHC board member; Bruce Smith, vice president and chief information officer of Lutheran General HealthSystem; Pat Skarulis, vice president and chief information officer of Rush-Presbyterian-St. Luke's Medical Center; and David Printz, vice president and chief information officer of MacNeal Hospital.

The CHIN board is responsible for making policy decisions, such as which functions should become operational first and when to bring individual hospitals and providers on-line. Security and confidentiality issues will also be addressed by the board. To protect information communicated over the CHIN, data are never stored in midpoint data banks of any kind, eliminating the possibility for "hackers" to break into a centralized data base.

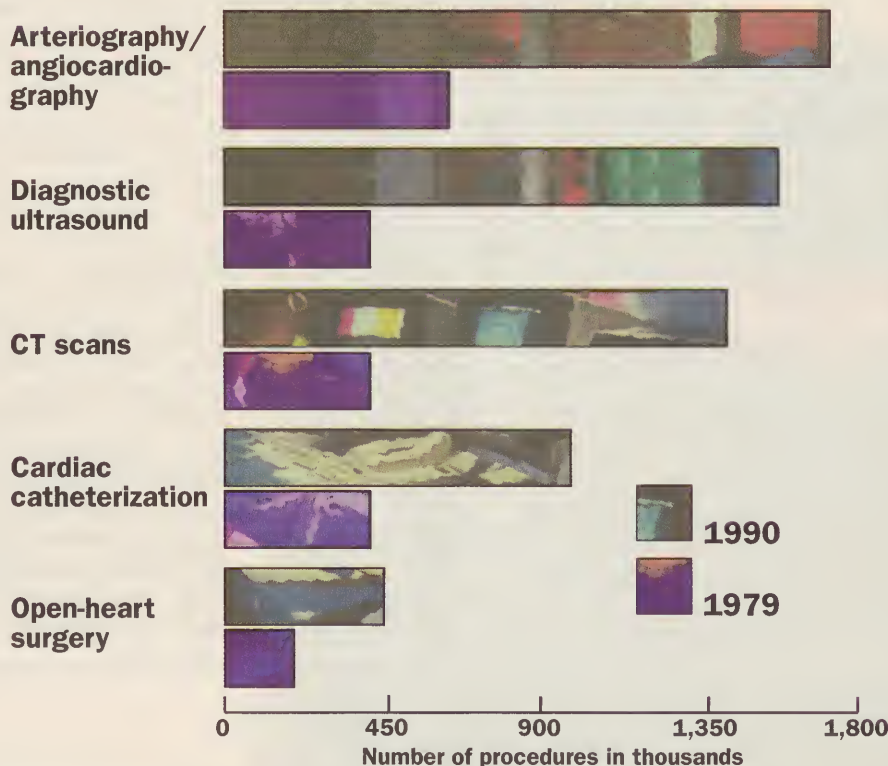
The CHIN Steering Committee, representing MCHC and ISMS, has selected ChinAlliance as the vendor that will coordinate all CHIN functions and services. MCHC and ISMS are negotiating a master agreement with ChinAlliance, nationwide entities that provide such products and services as information software, physician-hospital data transfer, electronic claims processing and pharmacy billing. The primary contractor is Shared Medical Systems of Malvern, Pa.

Bylaws for the CHIN are also being formalized. A supermajority vote of board members is expected to be necessary for decisions on key policy issues, such as the network's structure, financing, function and operation.

To participate in the network, physicians must have access to a computer and modem. Details about joining the network will be available soon. ■

PHYSICIAN FACTS

Frequency of high-tech diagnostic and surgical procedures



Source: U.S. National Center for Health Statistics

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Joint Commission releases quality reports

DISCLOSURE: The public will soon have access to accreditation report cards for 1,500 health care facilities nationwide. BY KATHLEEN FURORÉ

[OAKBROOK TERRACE] As part of its expanded public disclosure policy, the Joint Commission on Accreditation of Healthcare Organizations will start releasing once-confidential reports on hospitals and home, mental health, long-term care and ambulatory care facilities that have been surveyed since Jan. 1, 1994. This will give consumers access to accreditation reports on about 1,500 health care facilities – seven of them in Illinois – in mid-December, said JCAHO spokesperson Alice Brown. The number of reports released to the public will increase as JCAHO completes scheduled accreditation surveys of facilities throughout the country.

A complete catalog that includes report cards for all of the approximately 11,000 JCAHO-accredited organizations is expected by late 1996 – the end of the first three-year accreditation cycle under the revised public disclosure policy, Brown said.

"This is a carefully considered decision to respond to the growing need of various publics for meaningful information about the quality-related performance of this country's health care organizations," said JCAHO President Dennis O'Leary, MD.

sponsored a resolution stating that the report cards will create misperceptions for health care consumers. The resolution was adopted with changes.

In response to such concerns, the Joint Commission has stressed that when consumers select a health care facility, they should consider other factors in addition to the reports, Brown said. "We've also been very careful to say the reports

shouldn't be the sole determining factor used in making a health care decision. They're just one tool consumers can use to select a health care facility for themselves or their loved ones."

To help the public understand the report and put the results in perspective, JCAHO will include an explanation of the accreditation process with each performance report, Brown noted. "We've

tried to be clear that the performance reports are based on our accreditation decision."

In fact, the reports reflect facilities' compliance with more than 700 standards the Joint Commission uses to evaluate providers during the accreditation process. Compliance with those standards is a likely indicator that a facility will provide good care, she noted.

The reports, priced at \$30 each, are available through the Joint Commission's customer service center at (708) 916-5800. A 15-percent discount is offered to anyone requesting 25 or more reports. ■



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REPORT for Illinois Physicians

ILLINOIS MEDICARE PART B

DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

In a collaborative effort between the Health Care Financing Administration and the American Medical Association, Documentation Guidelines have been developed for Evaluation and Management (E/M) CPT* codes, which in 1995 will include new definitions of terms used in the codes. These guidelines will be used by Medicare carriers in reviewing medical records for appropriate levels of service billed to Medicare.

The Medicare carriers are training physicians in the understanding and use of the guidelines over a six-month period. In Illinois, the guidelines were published in the November Medicare B Bulletin and will be sent separately to all providers to whom they apply. A training video on the guidelines will be available for loan. The guidelines will be presented at the 51st Annual Midwest Clinical Conference in January, 1995. The Medicare Medical Director will be available to discuss the guidelines at other professional society meetings.

After this training period, physician billing patterns for the E/M codes will be reviewed for three months, during which further education can be offered. Thereafter, carriers will be instructed to employ the guidelines in reviewing E/M claims.

*We've been very careful
to say the reports
shouldn't be the sole
determining factor used
in making a health
care decision.*

Each report card includes an overview, the accreditation decision and date, the organization's overall evaluation score, scores in 28 performance categories compared with the national averages for similar organizations or facilities, and areas for which improvements were recommended, Dr. O'Leary explained. Among the areas evaluated in JCAHO accreditations are patient care functions, service providers and staff, physical environment and safety, and organizational leadership and management.

"The Joint Commission and accredited health care organizations are keenly aware that we are accountable to those we serve – the American public," said John Laing, PhD, JCAHO's vice president of marketing and external relations. "The performance reports are one way to ensure that the public has access to relevant information."

Because the reports don't consider such variables as individual physicians' records, outcomes of specific procedures or the health and demographics of the patient populations served, ISMS expressed concern to the AMA last spring that the reports may not paint a complete picture of a rated facility's quality. In addition, at the 1994 AMA Annual Meeting, Illinois physicians

* CPT five-digit codes, two-digit numeric modifiers, and descriptions only are © 1994 American Medical Association.

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EDITORIAL

Moving closer to a medical majority

What a difference an election can make. In the Illinois House, candidates who support tort reform defeated 12 incumbent opponents and won an open seat. We also gained a caps supporter in the Senate. As a result, we're closer to realizing a medical majority in the General Assembly. To some extent, the election results in Illinois mirror those in other states. But in achieving Illinois' pro-tort reform outcome, other factors came into play – namely, ISMS members who donated their time and individuals who contributed to IMPAC, the Society's political arm.

IMPAC played a leading role in many campaigns. Through a survey, candidates were asked about their positions on various issues, including tort reform, expanded scope of practice for allied health practitioners and utilization review. That information was then distributed to voters through Illinois Medicine coverage and was available to phone callers. IMPAC donations were distributed strategically to support physician-friendly candidates, especially supporters of caps.

Long before the election took place, ISMS and county medical societies were at work. Statewide briefings were held to inform members about critical issues and the positions of some of the candidates in key races. All the participants deserve thanks, whether they spoke at the briefings or attended them. In addition,

many members worked on the campaigns of candidates in their districts. And your ISMS leaders traveled around the state speaking on the issues.

You know the results of all the hard work. In addition to producing many winners who support tort reform, the election cost Democrat Michael Madigan, a longtime opponent of tort reform, his post as House speaker. Taking his place will be Lee Daniels, a supporter of tort reform.

After thanking everyone, it's tempting to relax in the afterglow of this election victory. But we must focus on the next phase. To get the 60 votes in the House needed to pass a cap, we need the support of Republicans and Democrats alike. We're off to a great start, but we must still convince legislators of the benefits of caps in reducing frivolous lawsuits, defensive medicine and rising health care costs without sacrificing the quality of patient care.

Now that the U.S. Senate and House are also controlled by Republicans, the future of health care reform, under a Democratic administration, is uncertain. Through the Washington Presence program, ISMS will continue advocacy to preserve the physician-patient relationship and maintain high-quality patient care.

This election gives us a new opportunity to build strong relationships with legislators from both parties. Your time and continued IMPAC donations will help maximize our election gains.

PRESIDENT'S LETTER

In anticipation of wishes fulfilled

Alan M. Roman, MD



Despite all one hears about the splintering of medicine into polarized groups, physicians played an active role in these elections.

Flying low at 1,000 feet and at 220 miles per hour, the twin-engine Beechcraft skirted the O'Hare airspace on its descent into Frankfort's airstrip in the south suburbs.

I was returning from another stop on the President's Tour, this time visiting our state capital and the Sangamon County Medical Society. How I enjoy meeting our members and flying on clear nights like this one, with a half-moon illuminating the sky as a counterpoint to the glittering lights of Chicago. And how appropriate that on election night I should be returning from a visit to Springfield, a city that will soon have a lot to say about how medicine is practiced in this state.

Early reports indicated what was later confirmed – a big rebound for Republicans. Capitalizing on nationwide dissatisfaction with the Democratic agenda and our nation's failure to resolve many of its problems, Illinois Republicans defeated 12 incumbent House members and gained one open seat, resulting in a 64-54 majority. In the Senate, Republicans added one seat to their existing majority.

For doctors, the Republican takeover of the House and the presence of a medical majority seem to make tort reform more likely. For so many years, we've argued that lawsuit reform, specifically a cap on noneconomic damages, will slow the rising cost of health care without sacrificing quality.

Lawsuit reform, however, is still not a given. It will require strategic planning and sound implementation to avoid pitfalls. What is assured is that lawsuit reform, as well as other physician issues, will have a full airing in the new legislature. And despite the plaintiff bar, which will redouble its opposition, tort reform will be given a fair hearing with Lee Daniels as speaker of the House. Caps will have a much better chance of passage in the next session.

Your Society was instrumental in these election victories. From the beginning, we knew our future was in the House. ISMS is bipar-

tisan, but currently more Republican candidates share physicians' ideology. We projected Republicans could win 13 seats in this election. IMPAC invested its efforts and its dollars wisely in these races. We won nearly every race and had no surprise losses, though many of the Democrats we have enjoyed working with lost their seats.

Despite all one hears about the splintering of medicine into polarized groups, physicians played an active role in these elections. You exercised your unique role in encouraging your patients to vote for representatives who would preserve the high quality of care patients deserve. Your energy was an investment in the future of medicine. Our agenda is the public's agenda. Patients will be the election's biggest winners.

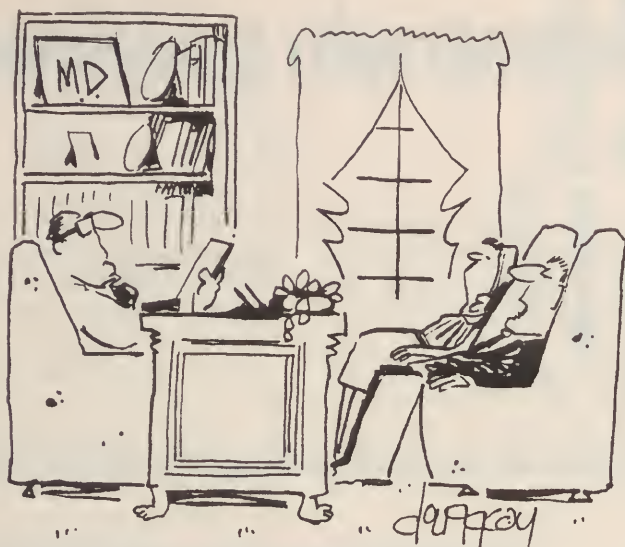
For the Society, the election means new relationships, new alliances and new opportunities. At the same time, there will be challenges to ISMS' positions on such issues as a single-payer system.

Yesterday's dream provides tomorrow's opportunity for physicians to get to know some fresh faces in the legislature and to serve as their resources. It is an opportunity to educate and to build relationships. Clearly, knowing how starts with knowing when.

Tuesday evening, with election results portending a victory for medicine, though the plane was flying low, those of us involved in the process were flying high. How I wish we could have frozen that night in time and continued to savor the victory. All too soon, we will be worrying about how to hold onto the seats we've gained.

For now, however, at a time when physicians' stress is skyrocketing, when disability claims among physicians are rising and when some doctors are losing enthusiasm for their work, you are justified in feeling good about yourself, your colleagues, your profession, your accomplishments and your challenges. These feelings will be minuscule compared to the gratification and contentment you'll feel when caps become a reality.

Congratulations and sincere thanks from me to you.



"I can't afford a hernia operation right now.
I'm saving for a nervous breakdown."

Quotables

"I think the health care reform debate ran out of the starting gate heading the wrong way."

— **Mark Pufundt**, executive director of policy and membership services for the U.S. Chamber of Commerce's Midwest Membership Center, Business Insurance

"You get as far as seeing that it will double your state budget and then you don't look at it anymore. There is a real groundswell of anti-government sentiment, and it just comes absolutely in conflict with single payer."

— **Kala Landenheim**, George Washington University, Sacramento Bee

"American voters gave Congress a sharp shove to the right and raised new obstacles to President Clinton's legislative agenda and re-election hopes."

— **Washington Post columnist David Broder**

"There are some sides of professionalism that are at stake and are being destroyed. To refer a patient, you have to make 13 calls to some idiot in an insurance company. That's the way to discourage referrals, and it works."

— **Chicago physician Quentin Young, MD**, on the increased scrutiny of doctors by HMOs, Crain's Chicago Business

"The public has not been given the opportunity to see this army of private-sector decision-makers. You have private officials who are designed to second-guess doctors and who are really not accountable to very much."

— **U.S. Rep. Ron Wyden (D-Ore.)**, on utilization review case managers making treatment decisions, Philadelphia Inquirer

"We feel we need to be in control of [at-risk] contracts. A doctor with a pen in his hand probably controls the costs of health care more effectively than any other thing I can think of."

— **Robert Goodwin, MD, president of Physicians Care Inc.**, a network of 100 doctors in Kentucky, on how doctors can master capitation, AHA News

GUEST EDITORIAL

Physicians take charge in a managed care market

By Barry W. Uhr, MD

Ten years ago, a group of ordinarily risk-averse physicians took a bold step: They formed an independent practice association, or IPA, to contract with HMOs in the Dallas area.

Today, that early commitment to managed care is paying off. I and the 650 multispecialty members of Southwest Physician Associates successfully compete for contracts in a market that is increasingly demanding broad service packages paid for on a flat per-member-per-month basis.

A decade of experience in managed care and close affiliation with the Baylor University Medical Center allow us to efficiently offer — and accept risk for — services while maintaining high quality. I believe our experience could prove helpful to other physician groups struggling to maintain autonomy as networks sponsored by insurers and hospitals move in.

SPA was founded by members of Baylor's medical staff and has become one of the largest and most successful such organizations.

This success is the result of the cooperative efforts of a group of quality physicians practicing cost-effective medicine. We had a learning curve in our early years, but I am convinced that our physicians are now prepared for the increasingly managed medical care delivery system.

Much of the success of our organization is due to the dedication of its physician leaders. It has always been our belief that no one knows more about how to deliver medical or health care than physicians.

This did not happen without some difficulties. The early attempt to operate without gatekeepers temporarily impeded progress. As physicians learned what managed care really meant and as the primary care physicians became adept at guiding patients within the new system, we were on track.

SPA was selected by the medical staff board of Baylor University Medical Center to represent the medical staff in managed care contracting. The arrangement benefits both parties in competing for contracts. As more and more contracts are offered to physician groups, we feel fortunate to be positioned to bring our primary hospital to the table with us. Likewise, they are able to

bring to the table a large group of physicians who can contract.

SPA has developed the administrative capabilities necessary for functioning under these contracts. It credentials its physicians, has in-house capabilities to pay its primary care physicians, has computer on-line eligibility verification authorization and referral management and, in the near future, electronic claim submission using an integrated network communications system.

It has always been our feeling that physicians should be in charge of these activities, because we are the most capable of determining the quality of care being delivered. When the medical director is your colleague, the board of directors your associates and the members of the committees your peers, there is a trust that you don't have in other situations.

Recognizing the ever-changing needs of physicians, SPA formed a new management services organization with a stock offering to physician members. The offering was closed with physicians purchasing more than \$3 million of stock to capitalize the company.

We needed a mechanism for financing our continued growth and to facili-

tate the development of more primary care capabilities. SPACO Management Co. Inc., a Texas corporation, will provide administrative and management services for SPA and other physician groups.

If we are going to be employed by someone, we would prefer to work for ourselves. It doesn't seem right that we spent 10 years accumulating all this experience and not use it. It is not managed care

that physicians should really fear, but who manages that care.

We have learned that physicians can have some control over their destiny. Models such as SPA and SPACO allow physicians to stand up and look insurers directly in the eye and say that the business of medical care delivery to patients belongs to physicians and we have the ability to manage that care.

Dr. Uhr is an ophthalmologist in private practice in Dallas and is board chairman of Southwest Physician Associates and SPACO Management Co. Inc.



Photo courtesy of Illinois Historic Preservation Agency

ISMS PRESIDENT-ELECT Raymond Hoffmann, MD (center), accepts a commendation from Illinois State Historical Society officials Nov. 11 recognizing ISMS as a centennial business. According to the award certificate, ISMS was founded in 1840 and has strengthened the economy of the state and served Illinoisans for more than 100 years. The Kane and Peoria county medical societies were also recognized.

Federal government releases new mammography guidelines

PREVENTION: Agency aims to reduce breast cancer mortality rates. BY KATHLEEN FURORE

[WASHINGTON] New clinical practice guidelines designed to improve the quality of mammography and its potential for reducing breast cancer mortality rates were released in late October by the Public Health Services' Agency for Health Care Policy and Research. The guidelines – developed by a private-sector panel of physicians, other health care experts and consumers – outline the roles and respon-

sibilities of physicians, health care providers and patients involved in the mammography process, according to information from the U.S. Department of Health and Human Services.

There are two versions of the guidelines: one for consumers and another for radiologists, facility staff, and family physicians and other providers who refer women for mammograms, according to

HHS. "The guidelines will strengthen the ability of women to interact with their providers, fully aware of the type and level of service to which they are entitled," explained Philip Lee, MD, HHS assistant secretary for health and director of the Public Health Service. They will also strengthen the Mammography Quality Standards Act, which went into effect Oct. 1, he added. The

act establishes quality standards for mammography equipment, personnel, radiation dose, record-keeping and reporting, and it requires facilities to be certified by the FDA, Dr. Lee said.

A key recommendation the guidelines make is that mammography facilities give women written test results on-site or by mail, usually within 10 days, according to HHS Secretary Donna Shalala. Many women never receive mammogram results or get them late, due to poor communication or confusion about who should deliver them, she explained. "Such errors are unacceptable. They can cause a woman needless anxiety over a mammogram that is perfectly normal or, worse yet, can result in treatment delays or other consequences for a woman whose mammogram is abnormal."

The clinical guidelines state that mammography should be performed only with high-quality, modern, dedicated X-ray equipment and with film processors set up specifically for the mammography film being used. They also say that providers of mammography services should be qualified through appropriate training, experience, certification and licensing, and that the facility should have an effective, ongoing quality-control program that includes annual evaluation by a qualified medical physicist. Qualified radiologic technologists should also conduct frequent quality-control tests at specified intervals, the guidelines suggest.

THE PATIENT GUIDELINES advise women to schedule screening mammograms when their breasts are least tender; to avoid using powders, lotions or deodorants on the test day; and to bring information – including X-rays if possible – about previous mammograms, according to panel co-chairman Edward Hendrick, PhD, associate professor of radiology and chief of the division of radiological sciences at the University of Colorado Health Sciences Center in Denver.

"The guidelines offer excellent ideas," said Ob/Gyn M. LeRoy Sprang, MD, ISMS secretary-treasurer. "Breast cancer is one of the most common malignancies in women. One in eight or nine women will get it over her lifetime. That's why it's important to have high-quality equipment and specially trained people to perform mammograms. And it's important for physicians to tell their patients that it's risky to assume everything's OK if they hear nothing after having a mammogram. It's a good idea for patients to get a copy of their results. And if they don't, they should follow up, because it's possible their physician hasn't even seen a copy. Sometimes things get lost in the mail. I always tell my patients to call me about five days after their test so they know we got the results."

Physicians or patients who want a free copy of "High-Quality Mammography – Information for Referring Providers: Quick Reference Guide for Clinicians" or "Things to Know About Quality Mammograms: A Woman's Guide" should contact the AHCPR Publications Clearinghouse at (800) 358-9295, P.O. Box 8547, Silver Spring, MD 20907. ■



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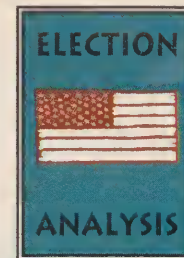
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ISMIE Update



Medical
majority may
bode well for
tort reform

PAGE 1

MALPRACTICE ROUNDUP

Court rules on cross-examination of expert witnesses

An Illinois appeals court has ruled that defendants' attorneys can cross-examine expert witnesses about current restrictions to the witnesses' medical licenses, according to a case summary in the September 1994 issue of Medical Malpractice Law & Strategy. The appeals court found that the trial court in *Creighton vs. Thompson* had not erred in permitting attorneys for two physicians and a medical group to elicit information from a physician testifying for the plaintiff regarding restrictions to his medical license in his home state. ■

Fear of contracting AIDS from physician not grounds for damages

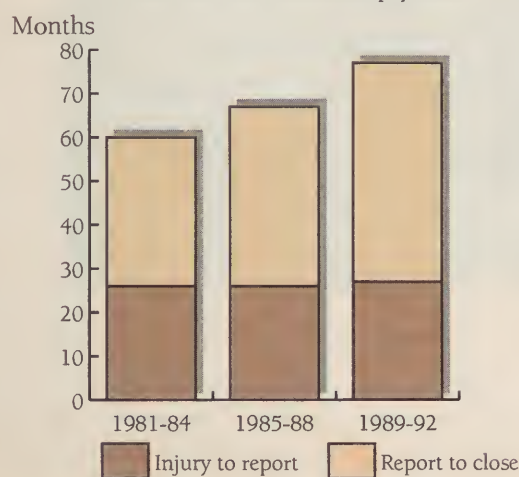
A California appellate court recently ruled that a woman afraid of contracting AIDS could not seek damages from the estate of a physician who operated on her four years before the disease claimed his life. In *Kerins vs. Hartly*, the court upheld a lower court decision and ruled that the physician's estate was not liable to the patient, even though he had performed the surgery on her prior to publicly announcing that he had AIDS, according to an article in the Sept. 19 issue of *Business Insurance*. The woman tested negative for the virus, the article said.

In addition, the court ruling stated that a "proliferation of similar claims could compromise the availability of dental, medical and malpractice coverage."

The decision in *Kerins vs. Hartly* was issued shortly after a California Supreme Court ruling on fear of contracting cancer after exposure to pollution, *Business Insurance* reported. In that ruling, the high court stated that those exposed to pollution can recover damages only if medical evidence shows they are "more likely than not to contract the disease due to the exposure." ■

Average time lapse from date of injury to date claim is closed

Illinois cases for claims with payment



Source: Illinois Department of Insurance, 1994 Medical Malpractice Claims Study

Terminating patient relationships requires care

When a change in caregiver is necessary, physicians should communicate and document. BY RICK PASZKIET

Sometimes physicians are faced with situations that leave them no choice but to end their relationships with patients. Perhaps a patient refuses to comply with a prescribed medical treatment, or the physician and the patient have a severe personality clash. Whatever the reason, the termination must be handled carefully.

"Today physicians are more cognizant of the potential problems posed by patient termination, and yet with the increase in their caseloads, doctors don't want to waste time with patients who flatly refuse treatment, especially when the non-compliance is egregious," said Kevin Glenn, senior partner with the Chicago law firm of Bresler, Harvick & Glenn Ltd. "On the other hand, the physician has to make sure that he or she is never seen in the position of 'abandoning' the patient."

There are no firm guidelines on when a patient should be terminated, according to Glenn. Instead, potential termination must be considered case by case. To an extent, the severity of the patient's condition dictates the physician's obligation.

"Obviously, a physician is putting himself or herself at risk when terminating a patient who is involved in a life-threatening situation," said Glenn. "A doctor's decision to terminate depends in part on what would be considered standard or reasonable care given the circumstances of the case."

"If a patient is late in paying one bill or doesn't immediately follow the doctor's advice to get some test done, terminating the patient relationship can be deemed excessive," Glenn continued. "Given a noncompliance situation, there must be significant documentation to indicate that the patient continuously disregarded the physician's line of treatment. The doctor can then demonstrate that he or she

was left with no choice but to sever the relationship."

Termination of the relationship does not mean that the physician is abandoning the patient, said Tim Kisabeth, MD, an Ob/Gyn from Alton. "In these instances, the physician is alerting the patient that

also state that the physician will be available to treat any immediate medical problems that occur during the notification period, Neville added. Patients should never be left with the impression that they are without medical care.

"The certified letter is a practical tool designed to prod the patient into action. Through it, the physician is identifying another caregiver or an 'entity' that would provide treatment," Neville said. "The object of the notification is to give patients the necessary referral knowledge so that they won't feel lost."

Physicians don't necessarily have to give patients a specific name and address of another doctor, but they can refer them to another source, such as a physician referral service or a county medical society that lists physicians who could treat them, Neville explained.

"Keep in mind that it is ultimately the patient's decision—not the physician's—that will determine who will be the follow-up medical caregiver," Neville continued. "In fact, there could be some potential problems for physicians if it seems as if their referral is a stamp of approval. As with any referral, physicians have to be careful about which medical sources they recommend for treatment."

Neville also emphasized the importance of a paper trail. Through certified letters and notations in the chart, physicians should clearly indicate that their communication with the patient is ongoing.

"My strongest advice to physicians is to go the extra step in patient termination," he said. "This means that after you've sent the initial notification letter, send another letter asking the patient to confirm that he or she has indeed found a new physician. The follow-up shows that you are concerned about the patient's medical treatment." ■

*There could be
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problems for
physicians if it
seems as if their
referral is a stamp
of approval.*

the relationship is going to end and that the physician will help the patient by providing additional medical sources to contact. Quite simply, the doctor is giving alternative treatment options to the patient."

The termination process must be well-documented, Dr. Kisabeth stressed. The file or chart must show that the patient was given ample notice of the termination, as well as information about where to go or whom to contact for treatment. "The physician is making certain that the patient won't fall through the cracks and be without medical care."

Once a physician has decided to end the relationship, the patient should be sent a certified letter with a return receipt requested, notifying him or her about the pending termination, advised Jim Neville, a partner with the Belleville law firm of Neville, Richards, DeFranco & Wuller. "The notification ranges from 30 to 60 days, so the patient has plenty of time to seek new medical treatment."

The termination letter should

ALLIANCE PROGRAMS

Promoting healthy lifestyles

Physician spouses are dedicated to improving the health of Illinois residents.

BY JANICE ROSENBERG

A crowd of parents listen to physician speakers discuss child care. Expectant teen-age mothers learn about nutrition, self-esteem and the danger signs in pregnancy. Seventh-graders tackle difficult social issues related to AIDS. Although the topics are different, the participants have something in common: They're benefiting from programs promoted by the Illinois State Medical Society Alliance and designed by county alliances to foster better health care in citizens around the state.

"We can't solve all the problems, but we can make a difference in each small area," said ISMS Alliance President Carolyn Kobler, of Rockford. "We see these programs as a way to stem the major problem of violence by taking care of individuals and by teaching parenting skills and health awareness to adults and young people."

The ISMS Alliance encourages county alliances to develop health-related programs independently or in cooperation with other county organizations, Kobler said. To create and sustain programs, Alliance members do everything from fund raising to conducting the sessions, she said.

During the ISMS Alliance's Fall Conference in October, representatives from the Sangamon, Adams and McLean county medical society alliances outlined programs they are conducting in their communities. The presentations showed how these three successful programs work and provided tips for developing similar programs in other communities.

MEMBERS OF THE SANGAMON COUNTY Medical Society Alliance have been involved with programs at the Care Center of Springfield since 1988. That year, the Care Center won ISMS' Public Service Award because of the center's dedication to promoting quality health care for indigent pregnant women and its work with the medical community to help deliver prenatal services and reduce infant mortality.

Pat Graham, a member of the Sangamon County alliance, attended that award ceremony. Inspired by

the Care Center's efforts, Graham visited the center to determine whether it needed any help and, if so, to see how those needs could be matched with the skills of fellow alliance members.

After her visit, Graham decided to establish a prenatal program for women who receive services at the center. The Care Center had already obtained educational materials from the University of Illinois for a program to teach prenatal and parenting skills to dysfunctional women. The alliance members used that program as a guide and built on it, Graham said. "Without any funds, we offered a pilot project of prenatal classes, and about 10 clients came. Then we went to the alliance and asked its members to take it on as a project."

With the alliance's backing, Graham and fellow members Gail Gauen and Jackie Vijil expanded their course into a 13-week session covering all aspects of pregnancy. "At the time, we all had small children at home," Graham said. "We brought them with us and used them to demonstrate nursing and bonding. For a long time, my daughter was best friends with the

Ron Ackerman



We're building their self-esteem, trying to make them goal-oriented and motivating them to get off Public Aid.

— Pat Graham

daughter of one of the women who came to the class."

The alliance eventually developed a weekly parenting session and play group for the center. Currently, the class offers guest speakers, films, ongoing support, discussions and information about other agencies that help young parents. The alliance has also organized free childbirth classes, Graham said.

"It's very rewarding. We're giving the women parenting facts and knowledge instead of myths. We're building their self-esteem, trying to make them goal-oriented and motivating them to get off Public Aid."

PARENTING IS ALSO the focus of Kid Care, a program conducted by the Adams County Medical Society Alliance for children who attend the Head Start School in Quincy and their families. This one-evening program was held for the first time in February 1994. Alliance members are planning to present the program again in February 1995.

"We chose the Head Start School because we wanted to give the parents there access to some health-related items they might not have [learned about] otherwise," said Karen Dieckhoff, chairperson of the Adams County program.

Seventy parents attended the program, which was held at the school because nurses and administrators said the children's parents already felt comfortable turning to the school for educational programming, Dieckhoff noted. Four area physicians led the program, with family practitioner Jerry Kruse, MD, talking about fevers; emergency room physician Richard Saalborn, DO, discussing seat belt safety; otolaryngologist Harry Ruth, MD, speaking on ear infections; and pediatrician David Lohmeyer, MD, presenting an overview about the importance of good parenting. After the presentations, parents participated in a question-and-answer session.

Because their children were being cared for in other parts of the facility, the parents were able to relax, listen and ask questions without interruption, Dieckhoff said. Some teen-age children of alliance members volunteered to baby-sit for the youngest children. Three- and 4-year-olds saw a puppet show, "doctored" teddy bears and played games in the gym. Older children watched a rap music video on bicycle safety and examined a human heart and eyeballs of farm animals.

Because Head Start provided the refreshments, the evening cost the alliance only \$170, Dieckhoff noted. "The Head Start nurses were thrilled. They kept saying that they wanted to do it again next year and that the parents must have liked it because no one [wanted to leave]."


"One thing they really enjoyed was hearing Dr. Ruth thank Dr. Lohmeyer, for the uplifting, moving things he'd said and for making him feel like a good person who could be a good parent," Dieckhoff said. "It took the doctors off the pedestals that some of the parents might have put them on."

AIDS IS THE FOCUS of a program developed by the McLean County Medical Society Alliance. The program – called Making Educated Life Decisions Through Drama – was created three years ago, after alliance members were approached by area organizations that wanted to bring an AIDS-education theater troupe to Bloomington.

"The cost was \$1,600 for a single day's program, and it wouldn't have reached very many people. So we decided it didn't make sense," said Mary Jane Willey, co-president of the alliance.

Instead, the alliance decided to create its own drama program to promote AIDS education. Willey said she

Lori Ann Cook



W

e listen to
what the kids
have to say
and try to correct
misinformation and
myths.

– Mary Jane Willey

contacted the theater department at Illinois State University, and Julie Brinker, an associate professor of drama, was eager to help. Brinker worked with the alliance to establish games for the program and taught the physician spouses how to facilitate those games.

Through the program, students participate in dramatizations crafted to help them understand how HIV is transmitted. They also play a question-and-answer game that resembles the television show "Family Feud."

In 1993, the program reached more than 1,500 students – mostly seventh-graders – in science classes. "We don't go to the classrooms with a set agenda," Willey said. "We listen to what the kids have to say and try to correct misinformation and myths. With creative drama, we tell kids there are no wrong answers."

The program also includes role-playing sessions. Students act out a scene in which a health care worker informs a person that he or she has tested positive for HIV. "Some kids think they're real cute," said Willey, who works as a classroom facilitator. "They say, 'You're going to die' and hand the other kid a box of tissues. The rest of the kids will boo that. Other kids have almost made us cry, they're so sympathetic. They put their arms around the person and say: 'I'm sorry. You're HIV positive, but that doesn't mean you're going to die. There are medicines to help keep you from getting AIDS sooner.'"

Parents are invited to attend the sessions, and even those who are skeptical about it at first are usually won over by the program, Willey said. To help establish similar programs throughout Illinois, the alliance has produced a training film about its program for use by other county alliances.

"Alliances have to look around their counties and see what's needed," said Kobler. "They can come to us for help. We encourage that very much." ■

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– Karen Dieckhoff




Photo Ideas/Chicago

More med students choosing general practice

SURVEY: Nearly half of graduating seniors say they plan to practice in small- to moderate-size cities.

BY KATHLEEN FURORE

[WASHINGTON] Interest in general medicine is on the rise, according to a 1994 study by the Association of American Medical Colleges. The survey revealed that 22.8 percent of graduating medical students are planning to seek certification in generalist specialties, up from 19.3 percent in 1993. The greatest gain was in family practice, with 13.1 percent saying they would enter that specialty, up from 9 percent in 1992.

Prior to 1993, the number of students pursuing careers in family medicine, general internal medicine and general pediatrics had been declining. Although 34.1 percent of students graduating in 1983 said they would enter those specialties, by 1992 that number had dropped to 14.6 percent.

"We are encouraged that these numbers represent more than just a transient blip on our screen," said AAMC Presi-

dent Jordan Cohen, MD. "I think we're seeing the beginning of a turnaround."

This year's results, however, fall short of AAMC's goal for meeting the nation's needs regarding its physician workforce: for half of all medical school graduates to pursue careers in general medicine, Dr. Cohen said.

Graduating medical students showed less interest in internal medicine specialties, pediatric and Ob/Gyn subspecial-

ties, anesthesiology, emergency medicine and radiology. For example, students planning to go into internal medicine subspecialties fell to 12.2 percent in 1994, from 16.4 percent in 1992.

Of those favoring generalist specialties, 49.9 percent said they plan to practice in small- to moderate-size cities, 20.3 percent in rural areas and 11.6 percent in large cities or suburbs. And 25.6 percent of those interested in general medicine said they plan to practice in socioeconomically deprived areas. In contrast, only 6 percent of all respondents said they would practice in rural areas, and 11.4 percent said they would set up a practice in a socioeconomically deprived area. ■

MEMBERS IN THE NEWS

David Benjamin Littman, MD, a Highland Park internist and ISMS' second vice president, has been appointed by Gov. Jim Edgar to serve on the state's Medical Licensing Board, which reviews medical license applications and examinations.

In a letter to Dr. Littman, Edgar said: "Your appointment is a partnership with me in carrying out this board's responsibilities for the benefit of all the people of Illinois. Your experience and sound judgment will be a valued asset during your tenure in this important area of state government."

Dr. Littman, who is semi-retired and is with the Lake County Health Department, replaces outgoing board member Lawrence Hirsch, MD, of Northbrook. Dr. Littman's term will expire Jan. 8, 1999.

The American College of Emergency Physicians recently presented its 1994 EMS Awards to John Lumpkin, MD, and Stanley Zydlo Jr., MD, for their outstanding contributions to the field of emergency medical services. The awards were presented in early fall during ACEP's Scientific Assembly in Orlando.

Dr. Lumpkin is director of the Illinois Department of Public Health. He is also an emergency physician at Chicago's Northwestern Memorial Hospital and a clinical assistant professor in emergency medicine at Northwestern



Dr. Lumpkin

University. Dr. Lumpkin has served as the legislative committee chairman for ACEP's Illinois chapter since 1985 and as a board member of the national organization for almost a decade. He was recently appointed to the U.S. Centers for Disease Control and Prevention's Lead Advisory Committee and the U.S. Health Resources and Services Administration's AIDS Advisory Committee. In addition, Dr. Lumpkin has served on the U.S. Department of Health and Human Services' Secretary's Advisory Committee on Injury Prevention and Control.

Dr. Zydlo is chief of emergency

medical services at Northwest Community Hospital in Arlington Heights. He has been named chairman of the Project Medical Directors Consortium for Chicago's EMS system annually since 1984 and has presented hundreds of EMS-focused lectures and seminars throughout the country. The EMS system for the northwest suburbs pioneered by Dr. Zydlo in 1972 has served as a model for similar systems nationwide.

Anthony Geroulis, MD, is the recipient of the 1994 Most Distinguished Greek-American in the Field of Medicine award, which is presented annually by the United Hellenic Voters of America. Dr. Geroulis is a board-certified cosmetic surgeon and a clinical associate professor of surgery at the University of Chicago. He has offices in Chicago and Wilmette.

Ned Zallik, MD, is the new medical director of Glenview Terrace Nursing Center in Glenview. Dr. Zallik, who is board certified in internal medicine and geriatrics, is a staff member at Rush-Presbyterian-St. Luke's Medical Center in Chicago and Rush North Shore Medical Center in Skokie. He is also medical director of the Rush North Shore Alzheimer's Disease Center. His professional memberships include the American Geriatric Society and the American College of Physicians.

Steven Pinsky, MD, president-elect of the Illinois Radiologic Society, was named one of the top U.S. general nuclear medicine specialists in the 1994-95 edition of Best Doctors in America, a publication that lists the top 2 percent of practicing physicians in the country. Dr. Pinsky is a professor and head of the department of radiology at the University of Illinois at Chicago College of Medicine.

A graduate of Loyola University's Stritch School of Medicine, Dr. Pinsky has served on the medical staffs of the University of Chicago Hospitals and Michael Reese Hospital and Medical Center. He has been a UIC faculty member since 1989.

Three Illinois physicians have been named to the Cancer Liaison Program of the American College of Surgeons'

Commission on Cancer. The new cancer liaisons are Gregory O. Harrison, MD, Memorial Hospital of Carbondale; Thomas Hoeltgen, MD, Christ Hospital and Medical Center in Oak Lawn; and Zivojin Pavlovic, MD, Methodist Hospital of Chicago.

With their three-year appointments to the program, Drs. Harrison, Hoeltgen and Pavlovic have joined a national network of more than 2,000 physician liaisons who provide leadership and support to the Commission on Cancer. Specifically, the liaisons promote communication and consultation among family physicians, surgeons, medical oncologists, diagnostic radiologists, radiation oncologists, pathologists and other cancer specialists to provide better patient care, according to the commission.

Earlier this year, 93-year-old general practitioner Nelson Wright Jr., MD, celebrated 65 years in medicine. He opened his family practice in Pekin on March 21, 1929.



Dr. Wright

Dr. Wright still sees about six patients a week and is gradually referring patients to his son Nelson Wright III, MD, who became his

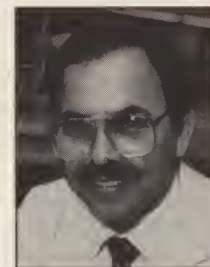
partner in 1961. Another son, Robert Wright, MD, is a radiologist in Peoria, and his grandson, David Wright, MD, is an allergist practicing in Gainesville, Fla.

Many of Dr. Wright's current patients have seen him for 50 or 60 years.

Holy Family Medical Center in Des Plaines has announced four new members to its medical staff. Ophthalmologist Marshall Hirshman, MD, earned his degree from the University of Illinois' medical school and completed his residency at Chicago's Michael Reese Hospital and Medical Center. Richard I. Katz, MD, also an ophthalmologist, is a Chicago Medical School graduate who did his residency training at the University of Missouri. Erwin Szela, MD, an Ob/Gyn, graduated from Rush Medical College and was a resident at Northwestern Memorial Hospital. Cardiologist Elaine Winkel, MD, earned

her medical degree from Loyola's Stritch School of Medicine and completed her residency at Loyola University Medical Center.

Arturo Chavarria, MD, is the new medical staff president at EHS Christ Hospital and Medical Center in Oak



Dr. Chavarria

Lawn. He will serve in that capacity through December 1996. Dr. Chavarria is a board-certified internal medicine specialist who joined EHS Christ Hospital in 1980 after completing his

residency training at the hospital. He earned his medical degree from Rush Medical College.

EHS Christ Hospital also named Rajeev Nagpal, MD, to head its gastroenterology division of pediatric services. Dr. Nagpal has extensive experience in pediatric gastroenterology and was an assistant professor of pediatrics at Chicago's Rush University.

After completing a pediatrics residency at Schneider Children's Hospital in New York, he won a three-year fellowship in pediatric gastroenterology at Children's Hospital of Philadelphia. A graduate of Delhi University in India, Dr. Nagpal's primary research interests include inflammatory bowel disease and cholestatic liver disease in children.



Dr. Nagpal

The United Cerebral Palsy Association of Greater Chicago recently honored Henry B. Betts, MD, with its Infinite Individual Leadership Award for his efforts to change society's attitudes toward the disabled.

Dr. Betts is medical director and CEO of the Rehabilitation Institute of Chicago. He worked for passage of the Americans with Disabilities Act and for legislation dealing with such issues as the use of seat belts and child safety seats and prevention of drunken driving.

Election analysis

(Continued from page 1)

al's race, DuPage County State's Attorney Jim Ryan defeated Winnetka plaintiff attorney Al Hofeld, who staunchly opposes capping noneconomic damages and refers to his legal victories over special interests like the "medical establishment." Incumbent Secretary of State George Ryan easily beat Patrick Quinn. During his first term, Ryan has tackled health-related issues, such as increasing the number of Illinois drivers who agree to be organ donors and proposing a lower legal blood alcohol limit for drivers.

Other winners who have had good working relationships with physicians include Loleta Didrickson, who beat state Sen. Earlean Collins (D-Chicago) in the comptroller's race, and state Sen.

Judy Baar Topinka (R-North Riverside), who defeated Nancy Drew Sheehan in the contest for state treasurer. Both actively supported issues important to medicine during their legislative careers. For example, Didrickson and Topinka were among the first sponsors of an ISMS-prompted bill calling for a \$250,000 cap on noneconomic jury awards.

IMPAC, the Society's political arm, played a major role in helping several supporters of tort reform win their House races against 12 incumbents. "Because the timing was right, IMPAC pulled out all the stops for this year's election," said IMPAC Chairman George Wilkins Jr., MD. "We're pleased with the outcome, but we're more concerned about rebuilding our resources. We're going to need to work even harder come the next election, to hold onto our gains."

"We couldn't have been so successful without the financial and personal support of many ISMS and ISMS Alliance members," he continued. "However, only 40 percent of the ISMS membership

contributes to IMPAC. We're in for a disappointing 1996 if this number doesn't come up. IMPAC can't do it alone. Politically active members must get their colleagues involved."

The Republican capture of the state Senate seat in the 29th District, which encompasses the north suburban Chicago area, is a pivotal victory for physicians. In that contest, tort reform proponent Kathleen Parker, who received strong backing from IMPAC and the district's more than 800 physicians, defeated incumbent Democrat Sen. Grace Mary Stern, who opposes caps. Parker has said that tort reform is the key to health care reform in Illinois.

In the 100th House District, which covers Springfield, ISMS Alliance member Gwenn Klingler defeated former Illinois State Bar Association lobbyist

Marylou Lowder Kent. IMPAC assisted Klingler throughout the campaign.

Two congressional races proved positive for physicians as well. In a race between two veterans of the Illinois House, Jerry Weller (R-Morris) beat Frank Giglio (D-Calumet City) and will represent the 11th Congressional District. ISMS backed Weller because of his track record on issues affecting physicians, especially tort reform.

Republican Ray LaHood, who also received organized medicine's support, beat lawyer Douglas Stephens in the 18th Congressional District, which includes Peoria and surrounding areas. With his victory, LaHood, who was chief of staff for U.S. House Minority Leader Bob Michel, retains the House seat for the Republicans.

Results of the Illinois elections echo those nationwide, with Republicans gaining control of both houses of Congress. This election marked the first time since 1954 that a political party lost the House and Senate in a single election. ■

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Touchette Regional Hospital opens sickle-cell center

[CENTREVILLE] Sickle-cell patients in Centreville can receive maintenance treatments close to home at the new sickle-cell center at Touchette Regional Hospital. Previously, area patients had to travel out of state to St. Louis for regular monitoring aimed at reducing the number and severity of crisis situations caused by the disease, said Enone Collier, RN, the hospital's sickle-cell program director.

In patients with sickle-cell anemia, the red blood cells change from normal round cells to crescent-shaped cells, Collier explained. Patients who regularly report to the center undergo lab tests to analyze their red blood cells and receive intravenous therapy and blood transfusions as needed. Patients' treatment records are sent to their personal physi-

cians, she said.

"All physicians will continue to take care of their patients," noted Abid Nisar, MD, a hematologist who serves as the sickle-cell program's medical director and has worked with sickle-cell patients for nearly 15 years. "When they need special care, we're here. We want to enhance their treatments and make a difference in their lives."

In addition to providing regular monitoring, IV therapy and blood transfusions, the center's staff teaches patients about their disease and its treatment, Collier said. "Education will be an important component of patients' visits. For example, patients need to know the importance of drinking plenty of fluids to prevent dehydration." ■

DURING THE DEDICATION of Loyola's new cancer treatment and research center this fall, Richard Fisher, MD, director of the Loyola Oncology Institute, details the features of the new facility. The \$30-million center was designed to facilitate treatment in a managed care environment and will provide cancer patients with comprehensive, efficient and cost-effective care.



Terry Vitacco

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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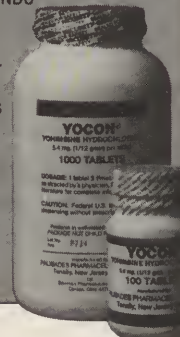
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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High-quality physicians

(Continued from page 1)

Health care organizations have traditionally turned to commercial search firms to help them recruit physicians, but these firms are on the decline, he said. To fill the void, firms like his offer training programs to help health care organizations create in-house recruitment programs.

"Primary care physicians have never been more difficult to recruit than now," Tilden said. "In many states, including Downstate Illinois, recruiting of a single physician can take from six months to a year." That's because the

demand for primary care physicians far exceeds the supply, he said. For instance, only 2,418 family practice residents completed their training in 1994, and another 8,513 are scheduled to finish residencies in the next three years. But with the demand for family practitioners estimated at 15,000, shortages will continue, Tilden noted. Adding to the problem are high retirement projections for primary care doctors, he said. "We need to cut subspecialties and mandate that medical schools produce more primary care physicians."

Because of the increased competition among the entities recruiting primary care physicians, managed care organi-

zations will have to do more than sell themselves to the physicians they are trying to recruit, Tilden explained. "It's not a question of selling or marketing yourselves, but of finding a good match between the community's needs, the physician's needs, his or her spouse's and children's needs and the needs of the specific health care group, hospital or clinic."

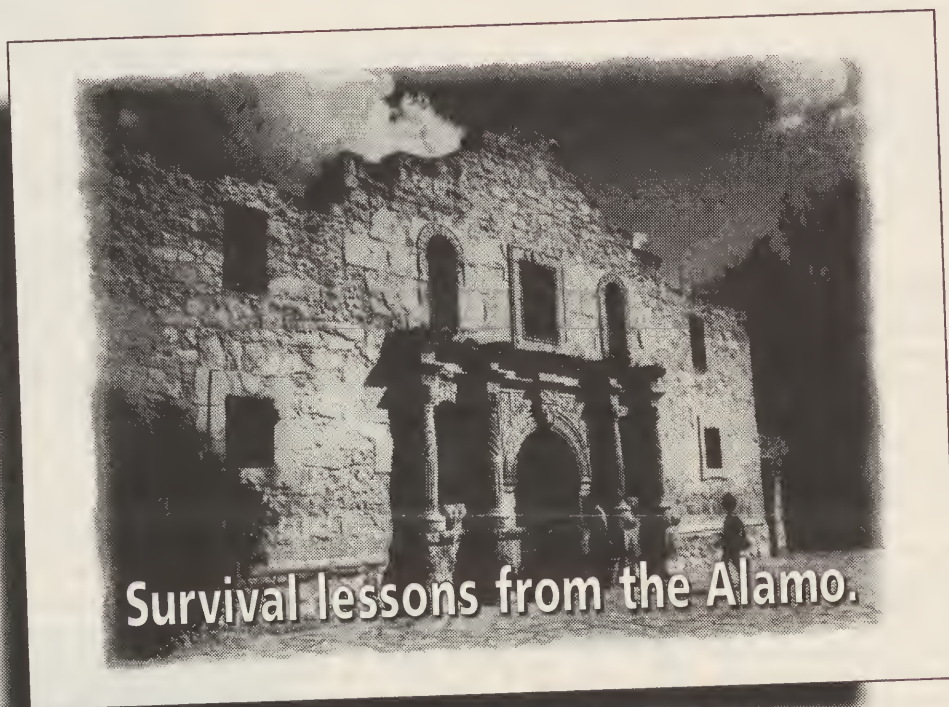
Recruiters will also have to address the special needs of female physicians, since women are expected to make up one-half of all doctors by the year 2050, Tilden said. At the top of that list are flex time, opportunities for job sharing, part-time positions, help find-

ing child care and an understanding environment.

LOCALLY, LUTHERAN GENERAL Hospital in Park Ridge is trying to expand its physician hospital organization, the Lutheran General Health Plan and its affiliated multispecialty medical group, the Lutheran General Medical Group. The hospital is trying to attract more primary care physicians into both organizations, said Lee B. Sacks, MD, vice president of the health plan.

Of the 583 physicians in the PHO, only 25 percent are in primary care, Dr. Sacks said. "This is the second-largest group of economically aligned primary care physicians in Chicago, but it is still grossly out of balance."

Of the 240 physicians in the medical group, 39 percent are in primary care fields, he added. This high percentage is the result of good recruitment practices coupled with an offer of secure jobs, job sharing, good salaries and other perks, Dr. Sacks said. ■



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August 1994

Sarz Maxwell, Chicago — physician and surgeon license and controlled substance license placed on indefinite probation for a minimum of five years due to a substance abuse problem.

Jamal D. Mustafa, Fort Washington — physician and surgeon license placed on indefinite probation for a minimum of four years due to a substance abuse problem.

Steven Pinkert, Glencoe — physician and surgeon license indefinitely suspended for a minimum of two years followed by probation for three years due to immoral conduct.

Viswanathan Prabhakaran, Sylvania, Ohio/Toledo, Ohio — physician and surgeon license indefinitely suspended after being disciplined in the state of Ohio.

Artura C. Sapida, Racine, Wis. — physician and surgeon license reprimanded after being disciplined in the state of Wisconsin.

William Thomas Sheehy, Elgin — physician and surgeon license reprimanded due to dishonorable, unethical and unprofessional conduct.

Burton Armin Waisbren, Boston — physician and surgeon license indefinitely suspended after being disciplined in the state of Massachusetts.

Medicaid plan

(Continued from page 1)

These patient defaults into capitated systems are expected to occur initially only in the Chicago and East St. Louis areas. MCCNs are new entities that are intended to be HMO look-alikes, serve only Medicaid patients and be governed and controlled by providers. However, these entities lack many of the protections of the regulatory mechanisms governing HMOs, according to an ISMS analyst.

While discussions continue, IDPA is waiting for the U.S. Health Care Financing Administration to approve waivers that will allow MCCNs to treat only Medicaid patients and will permit the department to assign primary care providers to Medicaid recipients who don't select one. The waivers will also lock recipients into assigned providers for one year. Current federal law prohibits state Medicaid programs from locking recipients into capitated systems for more than six months and from allowing more than 75 percent of a capitated entity's total enrollment to be composed of Medicaid patients. A final determination from HCFA is not expected until early next year.

MediPlan Plus was designed to be implemented by April 1, 1995, but that deadline will be difficult to meet because of the long federal approval process and the time needed to reach the 1.1 million Medicaid recipients affected by the program changes. "We're most concerned about the time and procedures involved in enrolling recipients by April 1," the ISMS analyst explained. "IDPA has to contract with a series of HMOs and MCCNs and sign contracts with fee-for-service gatekeepers before patient enrollment can begin."

In addition, IDPA's original proposal allows Medicaid recipients only 20 days to choose their primary care provider. This short response time could be problematic, in part because a significant number of Medicaid recipients — sometimes as many as 20 percent — change addresses each month, the analyst said. "There are dozens of reasons why a short choice period isn't really a choice period. We're advocating approaches like more time, multiple mailings and better information about fee-for-service providers, as well as capitated entities. We're urging IDPA to make this program more manageable."

"One of the major hurdles is getting patients enrolled where they belong," agreed William Kobler, MD, ISMS 12th District trustee and chairman of the Hospital Medical Staff Section. "There is a significant problem in notifying Medicaid patients."

Among the key points of the plan still being discussed is the fee-for-service gatekeeper system. As currently projected, this option calls for recipients to select an enrolled managed care provider, probably a primary care provider, who will be responsible for authorizing virtually all the care those patients need. Gatekeepers will be charged with providing and/or arranging for primary care services. In general, IDPA will pay for only those services authorized by enrolled managed care providers.

ISMS is attempting to ensure that the program allows sufficient flexibility for situations in which a specialist should serve as a patient's principal physician, the Society analyst said. In addition, ISMS is making recommendations to IDPA regarding requirements for the gatekeeper position, including how referrals should be handled.

ISMS is also providing input about the quality assurance, any willing provider, co-payment, and pediatric and mental health carve-out provisions of the MediPlan Plus program, the analyst noted. "We've already convinced IDPA to simplify the structure [of the gatekeeper provision] to make it more widely available to all physicians, to keep the approval process simple and to exclude OB services from the required prior approval mechanisms. We're also working on due process requirements to ensure a fair procedure before gatekeepers can be dismissed from the program. There are many very technical issues to deal with. We're advocating physician concerns to obtain a workable

program that has minimal bureaucracy and that maintains high-quality care."

"The State Medical Society is trying very hard to make the program work," said Dr. Kobler. "If we can do what the new program is attempting to do, there may be an improvement in the ability to control costs and in the delivery of health care to the Medicaid population."

Even with final details of MediPlan Plus still uncertain, physicians interested in participating in the program can take several interim actions. For example, doctors should determine whether the HMOs in which they currently participate intend to place bids with IDPA to treat Medicaid patients. Physicians can also ask about

their hospital's potential participation in an MCCN. Specialists can participate through referrals from gatekeepers, as well as through HMOs and MCCNs. Physicians should identify the Medicaid patients in their practice and discuss the pending Medicaid changes with them.

"Most [Medicaid patients] aren't used to working within managed care," Dr. Kobler noted. "Physicians can help their patients understand managed care and the choices they'll have to make."

ISMS will provide further details as they become available. Physicians who have questions may contact ISMS' division of health care finance at (800) 782-ISMS or (312) 782-1654. ■



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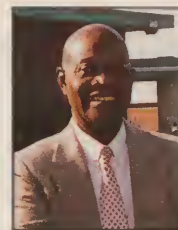
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12/21/94

Guess which public figures - whose photos were printed in 1994 issues of Illinois Medicine - are disguised as Santas. Watch for your next issue Jan. 13.

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • DECEMBER 16 1994



Healing in Haiti

PAGE 8

Member direction drives ISMS

Councils and committees offer ISMS members an opportunity to become actively involved in the Society and in organized medicine at the state level. By serving on councils and committees, you can express your views on topics affecting medicine and help direct the Society's actions.

The committee structure incorporates input from diverse physicians in such areas as public health, education and politics. Among the Society's physician councils and committees are the Council on Education and Manpower, which studies and evaluates all phases of medical education; the Committee on Health Care Access, which addresses access issues in rural, suburban and urban Illinois; and the Medical Legal Council, which focuses on legal developments that affect medicine.

Each council or committee is made up of between nine and 18 ISMS members who are appointed by the chairman of the ISMS Board of Trustees and approved by the full



Board. Since the councils and committees reflect the overall membership, physicians serving on them represent a cross section of medicine.

Some ISMS committees are made up of only ISMS

trustees, and others are a mix of trustees and members at large. To address a particular problem or concern that involves several groups' areas of responsibility, ad hoc committees are established as needed. For instance, last year, an ad hoc committee helped formulate the Society's reform-related activities. This year, it evolved into a new ISMS Board committee, the Committee on Health System Reform.

Council and committee members are typically selected because of their involvement at the local level. Many physicians first get involved in committee work at their hospitals, then participate in their county medical societies.

County societies also provide nominations for ISMS council and committee posts.

(Continued on page 13)

HCFA officials delay Medicaid reform plan

ISSUES: Federal regulators express concern about IDPA's proposed time line, enrollment and education processes. BY KATHLEEN FUREORE

[SPRINGFIELD] The U.S. Health Care Financing Administration has notified the Illinois Department of Public Aid that it questions key components of Illinois' proposed Medicaid reform program MediPlan Plus. As a result, the April 1, 1995, target date cannot be met for shifting 1.1 million Medicaid recipients into managed care plans.

Regulators have identified the issues "potentially most problematic to approval" by the federal government as being the implementation timetable, the request for a Section 1115 demonstration waiver that doesn't include eligibility expansion, carve-out problems affecting budget neutrality, recipient education, continuity of care and systems develop-

ment, according to a Nov. 29 letter from HCFA to IDPA Director Robert Wright.

"We do not feel that adequate time has been allotted for establishing a network that ensures access and continuity of care or allow[ing] for sufficient education of recipients," HCFA said in the letter.

In response, IDPA is addressing a list of 150 detailed questions from HCFA about the proposal and is planning to meet with regulators this month to discuss all areas of concern, said IDPA spokesperson Dean Schott. He confirmed that HCFA's questions will delay the program's implementation indefinitely. "It will slip from the proposed April 1 start date, but we have no concrete timetable yet. We're at the

(Continued on page 14)

Hearing focuses on health care needs of women

SOLUTIONS: Physicians and other advocates talk to Illinois legislators about access. BY JANICE ROSENBERG

[SPRINGFIELD] With talk of federal health care reform legislation off the front pages, Illinois legislators are considering local alternatives to improve access to health care. Participants in a recent hearing at the Illinois Capitol told the lawmakers that the General Assembly must pay particular attention to the health care needs of women.

"To solve the problems we're facing, you can't isolate one group from another," said Joan Cummings, MD, director of the Department of Veterans Affairs Edward Hines Jr. Hospital and chairman of ISMS' Council on Education and Manpower. "Health care reform needs all our input and everyone working hard to get things done."

The Nov. 14 hearing on the floor of the House of Representatives was sponsored by the

Campaign for Women's Health, a coalition of more than 100 national, state and grass-roots organizations working to advance women's interests in health care reform. Illinois was one of 10 states chosen to participate in the organization's state health initiatives project, and the hearing served as Illinois' contribution to the project. ISMS helped plan the event and sponsored a reception following the hearing.

Legislative hosts for the event were state Reps. Barbara Flynn Currie (D-Chicago), Judy Erwin (D-Chicago), Carolyn Krause (R-Mt. Prospect) and Rose

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Dr. Ali

Ron Ackerman

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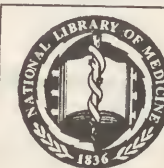
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Terry Vitacco

DURING A TOUR of the new emergency care center at Good Samaritan Hospital in Downers Grove, 4-year-olds from a local day care center play on a Ronald McDonald bench in the children's learning center.



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Regulatory concerns arising in Texas

GROWING PAINS: New questions, problems crop up as managed care proliferates. BY KATHLEEN FURORE

[AUSTIN, TEXAS] As managed care expands in Texas, so, too, do related questions and problems. The most recent concerns center on physician-hospital organizations and independent physician associations, which aren't reg-

MANAGED CARE

ulated under current state law, according to Leah Rummel, the director of HMO and utilization review for the Texas Department of Insurance. "We think those entities should be regulated," she said.

Specifically, the department contends that many Texas PHOs and IPAs are essentially operating as HMOs without licenses. That situation is problematic because the PHOs and IPAs are accepting financial risks they are unprepared to assume, Rummel noted. "We're seeing a boom of managed care business in Texas, and doctors are panicking. They're trying to form these organizations real fast without thinking about

the bottom line."

The HMO penetration in Texas is approximately 13 percent, Rummel said. That's up from 1992, when HMOs in the state covered 11.5 percent of the market, with more than 1.9 million Texans enrolled in 26 HMO plans, according to data compiled by the Marion Merrell Dow Managed Care Digest. The data also showed that 92 national and local PPO plans were operating in Texas in 1992, ranking it just behind California and Florida.

"So many of these [physician] organizations are popping up that we can't ignore the issue anymore," Rummel said. "You go to a hospital and see signs for [its] PHO product. It's become very blatant."

Because of the financial risks the Texas Department of Insurance suspects these newly formed PHOs and IPAs are taking, it is currently sending letters to the organizations explaining how the department will determine which entities are functioning as unlicensed HMOs. In

(Continued on page 10)

CDC releases new TB guidelines for facilities

[ATLANTA] To help reduce or eliminate the spread of tuberculosis in health care settings, the U.S. Centers for Disease Control and Prevention released guidelines in October for preventing the transmission of mycobacterium tuberculosis in health care facilities. The guidelines, which update recommendations released in 1990, were created because of concern over recent outbreaks of drug-resistant TB, the CDC said. Such outbreaks have occurred in at least eight hospitals and one correctional institution during the past few years.

"There were a number of outbreaks of TB — particularly multidrug-resistant tuberculosis — that began in late 1989 and went through 1992," explained William Jarvis, MD, chief of the Investigation and Prevention Branch of the CDC's Hospital Infections program. Consequently, a work group composed of occupational disease specialists and other health care experts revised the 1990 guidelines using the most current information about TB, Dr. Jarvis said. A draft of the new guidelines was published for the public comment in October 1992 and was then revised further based on the more than 2,500 comments received, he noted.

The 1994 guidelines advise health care facilities to conduct a TB risk assessment so they can implement controls appropriate for the level of transmission risk they face, Dr. Jarvis said. "This offers the facilities more flexibility than before."

Hospitals that see few, if any, TB patients or that always transfer such patients to another facility need only have a good triage system at the patients' point of entry, Dr. Jarvis said. However, those hospitals that examine and admit a substantial number of TB patients should use more stringent prevention measures.



Lloyd Young

ISMS FIFTH DISTRICT TRUSTEE Jane Jackman, MD, and ISMS Past President Robert Reardon, MD, tour Bloomington's new Community Health Care Clinic. The tour was part of an awards presentation at which ISMS was recognized for its contribution to the clinic.

Suburbs form coalition to promote health

[LA GRANGE] Improving the health and quality of life of west suburban Chicago residents is the goal of the new Healthy Communities Coalition, an alliance of community and health care leaders from Brookfield, Countryside, Hodgkins, Indian Head Park, La Grange, La Grange Park, Western Springs, Willow Springs and Lyons Township. By spring 1995, the coalition will have conducted a community health status assessment including statistics on infant mortality, heart disease death rates, death rates for alcohol-related traffic accidents, housing, jobs and public safety, according to a spokesperson for La Grange Memorial Health System Inc., which helped spearhead the initiative. The information will be gathered from local, state and federal health data sources, as well as from interviews with community leaders and residents.

"Community health status is determined by far more than medical care," said Rita Kopjo, a senior vice president

for La Grange Memorial Health System and a coalition member. "It is affected by the way people live, the kinds of jobs they have, how safe their neighborhoods are and a variety of other socioeconomic factors. To make an impact, we must work together as a community to address the root causes of health problems and shift our focus from treating disease to promoting wellness and emphasizing prevention and early detection."

Westchester family practitioner Kenneth Nelson, MD, also a coalition member, agreed: "Too often, hospitals have only looked at who comes in the door and what insurance they have. This is a way for us to look at everyone in a service area. If we don't make changes, we'll be faced with increasing debt, because when people don't lead healthy lifestyles it affects the whole community."

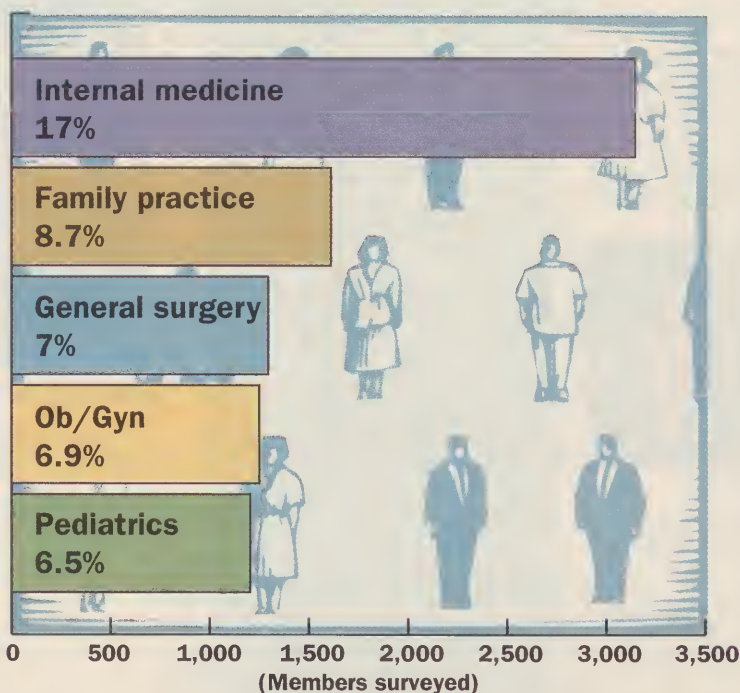
Using the assessment results, the coalition will draft a preliminary report outlining the health needs and priorities of the communities, the spokesperson said. Community groups, local governments and the public will have an opportunity to comment on the draft.

After the report is finalized, the coalition will create committees to address specific issues. For example, if the assessment uncovers a high incidence of smoking and heart disease, the coalition could work with the American Cancer Society to implement a smoking education program in local schools, Dr. Nelson explained. "Our goal is better health for the community, so we have to get down to the root of the problem."

Physicians in other communities should consider becoming involved in some type of community health assessment program, Dr. Nelson recommended. "It is important to take a proactive stand. Especially from a preventive medicine standpoint, anything that improves the overall health of patients should be fostered."

PHYSICIAN FACTS

Top 5 specialties of ISMS members*



*Includes all active members as of Dec. 1

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Inhalants seen as newest drug threat

EDUCATION: State launches campaign to fight growing form of substance abuse. BY RICK PASZKIET

[CHICAGO] Although many adolescents recognize the dangers posed by alcohol and illegal drugs, they are often unaware of the dire side effects of inhalants. As a result, inhalants have become more popular among teen-agers during the last few years, even though overall drug and alcohol use among young people has actually declined in Illinois, according to a recent study by the Illinois Department of Alcoholism and Substance Abuse.

"The good news is that fewer students are experimenting with alcohol and other drugs," said Lt. Gov. Bob Kustra, who coordinates Illinois' efforts to combat drug abuse. "The bad news, however, is that there's a marked increase in inhalant abuse among all grade levels. This presents us with a clear sign that we need to send out stronger messages to young people and their parents about the dangers of inhalant addiction."

One in every 10 high school students in Illinois has inhaled glue, writing markers, aerosol sprays, paint thinner and other products to get high, according to the DASA study. Inhalant use increased the most among Caucasian students. The percentage of Caucasian teens who have tried inhalants at some time in their life rose from 11.8 percent in 1990 to 12.4 percent in 1993.

"We need to recognize that inhalants are easily – and legally – obtained by teen-agers," said Kustra. "Inhalants have become the new experimental drug of choice. They rank fourth behind alcohol, tobacco and marijuana in substance abuse among Illinois young people."

"Inhalants cut across all class lines, [even though] to a certain extent, inhalants are a middle-class, suburban problem," he continued. "Suburban teens may not have access to crack, but inhalants are readily available right in their own homes."

To combat the abuse of inhalants, Kustra has initiated a public awareness campaign that has two objectives: to focus attention on inhalant abuse and addiction and to educate the public about the prevalence of inhalant abuse among teens. The campaign calls on drug prevention and health professionals, business representatives and law enforcement officers to become community partners and to implement the program locally.

More than 1,000 household products can be used by teen-agers to get high. And because of their ready availability, many young people believe that inhalants are less dangerous than drugs like cocaine or marijuana.

"Paint thinner in and of itself doesn't seem to be much of a threat, so young people assume, incorrectly, that inhalants are not that big of a deal," said Kustra. "But the dangers of inhalants are even more frightening than other illegal drugs. Recently, a 19-year-old student from Arlington Heights died from cardiac arrest after he used inhalants. This is a problem that we can't ignore."

Studies have shown the clinical and medical effects associated with organic solvents and aerosols. Any inhalant can cause severe and permanent brain damage, as well as loss of consciousness and irreversible damage to the liver, kidneys and bone marrow. There is also evidence

that chronic use of some inhalants causes chromosome and fetal damage.

"Sudden death, kidney and liver toxicity, and severe addiction can all be caused by inhalants," said Norman Miller, MD, chief of addiction psychiatry and director of the addiction treatment program at the University of Illinois at Chicago Hospital and Clinics. "It's important to remember that many inhalant users are also addicted to and

dependent on other drugs. Adolescents who experiment with inhalants usually turn to other illegal drugs."

Typical inhalant users are between 10 and 15 years old, although use may begin with 7- or 8-year-old children, Dr. Miller said. Inhalant use declines with age, as the users move on to other drugs, he noted. "Inhalants produce a hallucinogenic effect that adolescents are attracted to. Because inhalants are inexpensive and

available everywhere, their use is difficult, if not impossible, to control."

Besides a link between inhalant use and problems in school, there are other recognizable signs. "Parents may recognize that their child has a loss of appetite, spots or sores around the mouth, or is anxious and withdrawn," said Dr. Miller. "The important thing is to educate the child about the harm of inhalants before they begin to experiment."

"Right now, teen-agers and even their parents don't really understand the dangers and risks of using inhalants," Kustra concluded. "To prevent inhalant use, we have to educate our young people about its tragic consequences." ■



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REPORT *for Illinois Physicians*

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All physicians who have signed a BCBSI PPO contract must also have previously, or concurrently, signed a Mutual Participation Program (MPP) contract. Under this contract, participating physicians agree to accept as payment in full the BCBSI determined Usual and Customary (U & C) fee. Once again, the participating physician cannot balance bill the patient, but can bill for any deductible or coinsurance amount (up to a maximum of the U & C fee), or for any uncovered service.

Therefore, when participating physicians see patients covered under a BCBSI contract that allows for U & C fees, the physician can expect to receive a U & C fee. However, if the patient is covered by a BCBSI PPO contract, then the physician can expect the lessor of his/her billed fee, or the fee indicated by the SMA. Recently, BCBSI has received calls from some physicians inquiring as to why they were not paid a U & C fee for a service provided to a person insured under a PPO contract. The answer, of course, is that U & C fees are just not in effect for persons insured under the PPO contract.

Effective August 1, 1994, BCBSI modified the SMA to introduce in a step-wise fashion the physician compensation methodology known as Resource Based Relative Value Scale (RBRVS). This was discussed in a previous issue of the "Blue Sheet". This change in the SMA has resulted in further variances between the SMA and U & C payments, of which physicians are increasingly taking note.

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EDITORIAL

A pat on the back for the holidays

The unofficial theme of this holiday issue of Illinois Medicine is physicians who are making a difference. The feature tells the story of a Downstate doctor who opened a clinic in 1990 in Haiti, spending his own money to help build the facility and hire staff. He treated the poor for free and others for a nominal fee. The doctor left only when it became nearly impossible to buy medicine, but still sends money and medicine to the clinic he established.

A story on the front page describes how physicians and other health care providers traveled to Springfield to explain women's health care needs to legislators. The hearing covered such issues as increased access, mental health, drug abuse and aging. Through this type of program, legislators better understand the quality of care our patients deserve.

On Page 2 is a photo of ISMS Trustee Dr. Jane Jackman, who accepted an award recognizing ISMS' contribution to a Bloomington free clinic. With her was former ISMS President Dr. Robert Rear-don, who helped establish the clinic. Fortunately, there are many doctors who are working at free clinics or providing charity care.

An ISMS 1993 study found that two-thirds of Illinois physicians provide charity care, and 83 percent have maintained or increased the amount of such care over the last five years.

Although the latest available figures from the AMA are a little old, they showed similar results. In its socioeconomic survey, about two-thirds of all physician respondents had provided some charity care during their most recent complete week of practice, with the number jumping to three-fourths for general and family practitioners. Overall, physicians providing charity care spent 10.6 percent of their time in charitable service. How many other professions could make that claim?

The alliances are also busy with community-support projects. The Dec. 2 issue of Illinois Medicine featured programs developed by medical society alliances in Sangamon, Adams and McLean counties. Through these programs, the county alliances established a prenatal program for women at the Care Center of Springfield, conducted a parenting program for the Head Start School in Quincy and created a drama program dedicated to AIDS education. Fund raising is a priority, too. For example, the Macon County Medical Society Alliance announced in its newsletter that it had contributed \$44,232 this year to community projects.

So before you make those New Year's resolutions, take a moment to recognize what you and your peers have contributed this year. Happy holidays from Illinois Medicine and ISMS!

PRESIDENT'S LETTER

Holiday reflections

Alan M. Roman, MD



Holidays mark the end of one calendar year, the beginning of another. Holidays weave a story of family, friends and treasured moments.

When Daddy signs his name,
he always writes MD.
That's so everyone will know
that he belongs to me.

MD means "My Daddy,"
or something just the same,
and that is why he always
puts these letters behind his name.

Some letters in his name are small,
but these are not, you see.
He always writes them big like that
'cause he's so proud of me.

— Anonymous

This year, celebrate this wonderful, magical time of the year like a child. Go skating on the village rink until the lights go off, sculpt a snowman with a charcoal smile and relax with popcorn in front of a roaring fire.

You are the parent you are, in part, because you are a physician. No doubt, you are the doctor you are because of your family. Nothing is more important than those we love. They must always come first. Certainly, the paths of the children will reflect the lives of their parents.

To the gang that lives down your street, up your block, in your home or just within your heart, much health and happiness, and happy holidays from my family to yours and from all of us at the Illinois State Medical Society.



GUEST EDITORIAL

A private matter receives presidential attention, honesty

By Joan Beck

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The words were scrawled on two sheets of stationery, the handwriting cramped, the margins uneven, two words inked out completely. The tone was brave, gallant and accepting. The message tore your heart.

Ronald Reagan was going public with the stark fact that he has Alzheimer's disease – the terrible, progressive, incurable disorder that not only clouds the mind, confuses thinking and impairs judgment, but also steals the very essence of the self.

Reagan clearly understands the slow, inexorable decline that lies ahead. But his concern was for Nancy, not for himself. "Unfortunately, as Alzheimer's disease progresses, the family often bears a heavy burden," he wrote. "I only wish there was some way I could spare Nancy this painful experience."

There are three appropriate reactions to the cruel and stunning confirmation of what many people had quietly suspected for some time.

We can pray that the disease will progress slowly, as did parishioners at the Reagans' Bel Air Presbyterian Church and that he will be well enough for many years to "enjoy the great outdoors and stay in touch with my friends and supporters," as he said in his letter he plans to do.

We can use the public attention Reagan is calling to Alzheimer's disease to push for more research and more funding. Both are unexcusably meager for a disorder that now affects more than 4 million people and kills more Americans than anything else except heart disease, cancer and stroke.

Alzheimer's disease costs the nation an estimated \$82.7 billion a year. Care of a patient from diagnosis to death – which can range from three to 20 years – averages \$213,000. Alzheimer's patients fill half of the country's nursing home beds. The health care bills for Alzheimer's patients overwhelm most families, and the patients often have to be shifted to Medicaid.

Families provide 70 percent of the care Alzheimer's patients need, at an average cost of \$18,000 per year. No one can count the emotional price these caregivers pay.

A woman in Colorado wrote me about the pain of caring for a husband with Alzheimer's. "It was a 24-hour situation. The two hardest parts were taking the car keys away from him and finally having to put him in a nursing home. It cost me \$3,100 a month, leaving me destitute after his death. It took away two cars, a home, antiques – and the freedom I had taken for granted.

"Many times I would go down into the basement and just scream for a few minutes, releasing built-up pressure from the 24-hour caretaking situation."

Her sister, who also had Alzheimer's and with whose care she helped, "would cut pictures of fruit out of magazines,

place them on the dinner plates, and if we were not quick enough, would eat the pictures. One day we caught her making a dash for the front door wearing nothing from the waist down.

"To see two dear people die from this horrible affliction is something that never leaves you. So many times I ask myself – and God – why?"

"Now I am 74 and trying to cope with just my Social Security. The disease has left me destitute; depending on my family for support. To be unable to afford a car, a home of my own, to buy as I used to, to live in a one-room apartment, is to have my own freedom taken away, just as death took my husband and sister. I guess I'm not a very good human being."

Finding a cure for Alzheimer's or, better, a way to prevent it, would reduce the fear of old age, cut health care costs by billions of dollars and spare caregivers – most of them older women – terrible and lonely burdens.

Some small progress is being made. Physicians can identify characteristic lesions and abnormal accumulations of beta amyloid in the brains of Alzheimer's patients – at autopsy. One form of Alzheimer's disease may be related to a defective gene on chromosome 21. One drug, Tacrine, is on the market for Alzheimer's patients, but gives only limited help to some people.

Some research is being done in at least two dozen universities and medical centers. But it's far from enough for a disease that harms so many people, destroys so many families, costs the nation so much.

Public attention and contributions, inspired in part by Franklin Roosevelt, eventually led to the conquest of polio. A similar effort in honor of Ronald Reagan would be a fitting tribute to him and an enormous benefit to the nation.

The third response is stickier, but necessary. Legal experts should look again at the 25th Amendment, which covers presidential inability to discharge the functions of the office and make sure it protects the nation in case a president develops Alzheimer's disease.

The onset of the disorder is so insidious that it is possible an affected president could make blunders with horrendous consequences before his condition would trigger the provisions of the amendment. Some additional legislation might be advisable.

Reagan said in his letter he and Nancy talked about whether to keep his illness a private matter. They were moved, he wrote, by the fact that the experiences both of them had with cancer encouraged others to seek early treatment and saved lives.

"I now begin the journey that will lead me into the sunset of my life," the former president wrote. "When the Lord calls me home, whenever that may be, I will leave with the greatest love for this country of ours and eternal optimism for its future." Even at age 83, even in retirement, even with Alzheimer's disease, he is contributing to that future.



"They want a shorter workweek, a percentage of the milk and cookie dividend and a comprehensive health care plan or they walk."

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

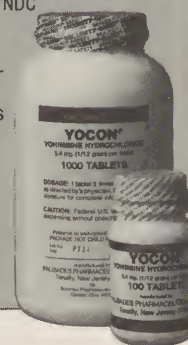
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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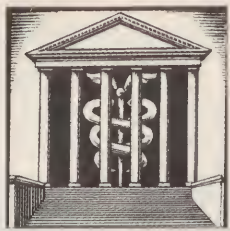
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Malpractice
Roundup

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ISMIE Update

ISMIE seminar
focuses on
liability in
managed care

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Choosing a malpractice carrier

Experts caution 'buyer beware' when insurers offer low rates. BY KATHLEEN FURORE

Selecting medical malpractice insurance is a task every physician must face. But given the number of choices, deciding on a carrier can be difficult.

"With the variety of physician-owned companies, risk retention groups, national multiline carriers and others in the Illinois market today, physicians have many more medical malpractice options to evaluate," said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. Consequently, physicians should thoroughly evaluate prospective insurers and consider more than premium rates when they choose a medical malpractice carrier.

For starters, doctors should research a company's stability and financial viability. "Physicians should make sure they're with a good, financially sound insurer," explained Bob Heisler, assistant deputy director of the Illinois Department of Insurance. "The most important thing for physicians is that their insurance company will be there to provide service when they really need it. Price [of premiums] should be a minor factor."

It's risky to use cost as the sole criterion for selecting a liability carrier, agreed Lori

Bartholomew, a consultant in loss prevention and research for the Physician Insurers Association of America. And doctors should be certain that a prospective insurer's surplus is not declining, she added. "If there are nine competitors, one might be undercutting without justification, just to capture part of the market. It might not be financially stable."

The case of U.S. Physicians Mutual is just one example of the risk physicians take when they base insurance decisions on price alone, Dr. Jensen said. The company was founded as a risk retention group by a physician seven years ago to write policies for orthopedists in several states, including Illinois. It is currently being liquidated. "The company founder believed that insurers kept rates high for lower-risk physicians to subsidize higher-risk physicians, and therefore the risk retention group offered appealingly low rates to its insureds," Dr. Jensen said. "Unfortunately, that

philosophy proved faulty and dangerous. Today, physicians previously insured by Physicians Mutual may have claims that can't be paid because their insurer is defunct."

TO ATTRACT NEW policyholders, some carriers offer more attractive rates, discounts and incentives than their competitors but soon raise premiums, Dr. Jensen noted. "When evaluating the soundness of a medical professional liability company, premium charges must be viewed cautiously. Companies that lowball rates may be seizing the moment and not reflecting the long-term nature of the medical malpractice insurance business, in which claims often arise well into the future. Sufficient premiums must be collected to pay such claims. The danger of becoming vulnerable to a pending lawsuit with an insurer who is unable to pay must be carefully weighed against the discounts often being proffered. The bottom line is that there is no free lunch. The high costs of defending malpractice suits don't change with low premiums — eventually the costs must be met."

Dr. Jensen noted that ISMIE does not

charge premiums to certain policyholders to cover the higher risk of other insureds. "In addition, ISMIE has maintained a strong track record for more than 18 years, while other carriers have come and gone in the Illinois market."

Exploring the types of loss prevention programs and CME activities offered by an insurer is also important, Bartholomew said. "It could be a home course, an attended course or some kind of loss prevention newsletter or other publication."

Physician-owned companies typically provide more of those programs and activities than other carriers, Bartholomew noted. "Physician-owned companies offer malpractice coverage exclusively, so they usually have more loss prevention programs and can provide more personal service than commercial carriers [that] also write home-owners and auto policies."

Doctor-owned medical malpractice insurance companies also use physician review committees as liaisons between the policyholders and the insurer, she said. "Physicians actively manage and take part in physician-owned companies."

Doctors can obtain information about insurers' stability, profitability and financial viability from the Illinois Department of Insurance, Heisler said. And Bartholomew recommended that physicians request prospective insurers' annual reports from the insurance carriers directly or from the Department of Insurance.

In addition, physicians may contact the Department of Insurance to check for complaints against a prospective carrier, Heisler advised. Doctors may also want to consult their peers and professional associations for information and advice about medical malpractice insurers.

Insurer raises rates, undergoes rate re-evaluation by A.M. Best

[CHICAGO] A New York-based insurer that recently began writing medical liability policies in Illinois has raised premiums for its 2,800 policyholders in Florida by as much as 30 percent, and its rating by A.M. Best Co. is being re-evaluated. Frontier Insurance Co. of New York, which provides liability coverage through its malpractice arm, the Medical Professional Liability Agency Ltd. (MedPro), has been given the go-ahead to increase its overall malpractice insurance rates in Florida by 12 percent, according to Florida Insurance Department spokesperson Karen Chandler. From 1992 through 1994, the state levied assessments totaling 8 percent of premiums on all property/casualty insurers in Florida, except those insurers writing only workers' compensation, auto liability or auto property and damage policies, she said. The assessments are expected to continue for at least four more years, Chandler added. And although other medical malpractice insurers applied for and were granted rate hikes this year, only Frontier requested a double-digit increase, she noted.

The rate increases range from 2 percent for some low-risk specialties to as high as 30 percent for gastroenterologists, said Thomas Dietz, MedPro president. The new rates go into effect Dec. 1 for new business and Dec. 31 for renewals.

Best is reviewing Frontier's A- rating "with negative implications," according to the Nov. 21 property/casualty issue of Best Week, a report published by Best. The evaluation stems

in part from Frontier's addition of \$17 million to its loss reserves, which has resulted in a \$2.3-million decrease in policyholder surplus since year-end 1993, the report said. In addition, Best is examining Frontier's vulnerability to pending lawsuits and the financial impact of potential future losses. "The complaints allege that the company previously omitted and/or misrepresented material facts with respect to earnings and profits," the report stated. Frontier claims the suits are without merit and will contest them.

"Our loss development in Florida is much worse than in other parts of the country. As we looked at it, we had no choice but to raise our rates," Dietz said, adding that Frontier anticipates raising rates again in the near future. "The request for this increase was made six months ago. Our actuaries have studied our books, and there undoubtedly will be further increases."

Frontier's rate hikes this year are its first substantial increase since entering the Florida market in 1987, according to Dietz and Chandler. Dietz acknowledged that the company made a slight rate adjustment last year, which reduced premiums for some physicians but increased them for others.

"We went into the Florida market with the intent of making a profit, and we did during the early years," Dietz said. "We started to see that profit eroding and had to raise our rates."

— Kathleen Furore



James Thompson

ISMIE seminar focuses on liability in managed care

EDUCATION: Participants learn about liability issues and risk management techniques. BY KATHLEEN FURORÉ

[CHICAGO] Responding to the need for information about liability issues in managed care, ISMIE presented a seminar for physicians and staff members who interact with managed care entities. Held Nov. 16 in Chicago, "Risk Man-



Dr. Martin-del-Campo

agement Issues in Managed Care" featured presentations by physicians, a loss prevention expert and an attorney. The program was moderated by Jere Freidheim, MD, chairman of ISMIE's Risk Management Committee.

"The shift of care from inpatient to outpatient settings and from fee-for-service medicine to managed care will continue in response to pressures to reduce cost," Dr. Freidheim said. "The ISMIE Risk Management Committee felt this change and its potential implications on liability for physicians was an important topic for our policyholders."

For physicians, the first rule is to avoid being lulled into a false sense of security, said Michael Wagner, a partner in the Chicago law firm of Baker & McKenzie. "Don't think you won't be named in a suit. I know of at least 10 plaintiffs' attorneys who have indicated

they're licking their proverbial chops over HMOs, HMO doctors and financial incentives."

Managed care contracts in particular include several potential liability risks for physicians, cautioned David Karp, loss prevention manager for the Medical Insurance Exchange of California. For example, physicians should beware of hold-harmless clauses that make them responsible for legal fees and judgments against the managed care entity, Karp said. And before signing a contract, doctors should ensure that the plan's managers have directors' and officers' liability coverage as well as regular professional liability and vicarious liability insurance. "We're seeing more and more managed care organizations being sued along with the physician. Under Illinois law, you're considered the deep pocket if you're the only insured."

Physicians should verify that their medical malpractice insurance policies cover all the services they will provide for managed care patients, Karp added. If the plan has a closed panel of providers, doctors should ask to see the names of participating physicians, since referrals are limited to those doctors.

To further minimize their risk, physicians should negotiate the right to refuse to treat patients if those patients fail to comply with the plan's directions, policies and procedures, or if the physicians are unable to establish a physician-patient relationship, said Alfred J. Clementi, MD, chairman of the ISMIS Board of Directors. Contracts should also permit physicians to determine medical necessity and appeal a plan's decisions.

Cost-containment components could



Dr. Freidheim

affect the quality of medical care, so physicians should evaluate them carefully, Karp said. For example, physicians should determine whether the plan limits diagnostic testing or medication choices or if it unduly restricts hospitalization.

PHYSICIANS PARTICIPATING in managed care should avoid basing treatment decisions on financial incentives, even though primary care physicians, especially those in HMOs, are often pressured to see as many patients as possible to increase the plan's efficiency and profitability, said Henry Martin-del-Campo, MD, executive associate director of the family practice residency program at Methodist Medical Center in Peoria. "A plaintiff's attorney will try to link an HMO physician who had voluntarily entered into a contractual agreement with an entity whose fundamental reason for existence is not better care but cost containment."

Doctors must explain any recommended treatment to their managed care patients and detail all the risks and options, Dr. Martin-Del-Campo said. Then all the recommendations and decisions should be documented. "Make sure patients understand they have the option of paying for a [recommended but not covered] procedure themselves. And document in writing or by dictation your recommendation that the patient needs a certain treatment whether insurance pays or not."

Karp also stressed the importance of documenting all communication with utilization reviewers, patients and specialists to whom patients are referred.

"Adequate documentation of your care not only ensures compensation but justifies treatment decisions and helps defend you in litigation."

PRIMARY CARE physicians should ensure their patients receive prompt approval, attention, screening, treatment and referral to specialists when needed, Wagner said. And specialists should accept patients promptly from primary care physicians, treat them as soon as possible and refer them back to the primary care provider when appropriate. In addition, specialists must inform gatekeepers about potential medical problems that could arise due to restrictions on care imposed by the plan, Dr. Clementi noted.

Specialists should also have a clear understanding of the care they are responsible for providing, said Janis Orłowski, MD, associate dean for medical sciences and services of Rush Medical College in Chicago and an ISMS Third District trustee. "Our greatest risk is in not clearly following through on the [treatment] plan. You need a mechanism to look back into the charts to see if the plan was followed. If I recommend and order a test, it is my responsibility to see that the test is done and that I get the results. I also need to record [the progress of] my plan. Have the patient, primary care physician and managed care plan followed through?"

Dr. Orłowski added that physicians should determine up front which plan employees to talk to about treatment decisions. "It is important to talk to someone with the same level of experience and training you have, so an appropriate decision for follow-up will be made."

Wagner also underscored the importance of documenting diagnoses, treatment and referral decisions. "To treat or not to treat may or may not be the question. But to document, that is the obligation."

Audiotapes and videotapes of this seminar are available on loan from the ISMIE risk management department. To borrow the tapes, call (312) 782-1654 or (800) 782-ISMS, ext. 1327. ■

MALPRACTICE ROUNDUP

Patient's ability to have children jeopardized

A New York appellate court recently ruled that a physician's failure to provide a timely diagnosis of a patient's ectopic pregnancy deviated from acceptable medical practice and deprived the patient of a significant chance of experiencing natural conception and childbirth. The plaintiff's fallopian tube ruptured before her ectopic pregnancy was diagnosed, according to a case summary of *Stewart vs. New York City Health and Hospital Corp.* published in the October 1994 issue of *Medical Malpractice Law & Strategy*.

During the trial, the defendant's expert witness testified that even if the fallopian tube had not ruptured, the plaintiff would have had only a 5-percent to 10-percent chance of conceiving a child through sexual intercourse. That calculation countered the opinion of the plaintiff's expert, who said that without the rupture of the fallopian tube, the woman would have had less than a 50-percent chance of conceiving again naturally, the summary said.

The trial court dismissed her claim for loss of child-bearing capacity, ruling that the evidence was legally insufficient to show "with reasonable medical certainty" that if the ectopic pregnancy had been diagnosed earlier, the plaintiff could have experienced a successful uterine pregnancy. But the appellate court ruled that even a 5-percent to 10-percent chance could be considered "substantial possibility." The court said the chances had to be only "more than slight" to constitute a substantial possibility that the plaintiff could have conceived again through sexual intercourse. Therefore, the court said the plaintiff had to prove only that she lost the 5-percent to 10-percent chance of becoming pregnant because of the rupture. ■

Suits filed against lactation suppressant manufacturer

At least six lawsuits are pending against Sandoz Pharmaceuticals Corp. in addition to seven related suits already settled by the maker of the lactation suppressant bromocriptine mesylate. Plaintiffs claim the drug increases the risk of strokes, seizures and heart attacks for new mothers who don't breast-feed and take the drug to halt milk production, according to an article in the *Medical Liability Monitor*. They also contend that the company promoted bromocriptine mesylate as a lactation suppressant, even though it was aware of the potential dangers of the drug in some women, the article said. About 7 million new mothers have used the drug to stop lactation.

In one recent case, a 22-year-old Texas woman became paralyzed and semicomatose after taking the drug. She is suing Sandoz, the hospital and her obstetrician for negligence. In another case, Sandoz is appealing an August decision to award \$2 million to a Kentucky mother who took the drug and was partially paralyzed by a stroke, the article said.

Sandoz maintains that bromocriptine mesylate is safe and contends that problems arise because women are sometimes more vulnerable to stroke, seizures and heart attacks after childbirth. However, in 1985, the U.S. Food and Drug Administration asked Sandoz to label the drug as contraindicated for new mothers with severe hypertension. The agency based its action on reports that after taking the drug to suppress lactation, 30 women suffered severe hypertension, 18 experienced strokes or seizures, and three died. Sandoz agreed to the FDA's requests and stopped promoting bromocriptine mesylate in 1989, but the company did not stop selling the drug. ■

CHARITY CARE

Healing in Haiti

An Illinois physician opens a clinic to treat poor and underserved patients in the Caribbean.

BY KATHLEEN FURORE

Centreville internist Rene St. Leger, MD, always dreamed of retiring to a seaside home in his native Haiti. But when he traveled there in 1989, it wasn't with retirement in mind: It was to build a clinic to treat the poor and underserved residents in his besieged homeland.

"I was very comfortable. I had everything I could want – a successful practice, my beautiful wife. But I started reading [about conditions in Haiti], and little by little, I began to think, Do I deserve all this? With a clinic, maybe I can help, even if I save just one life or two. I knew I couldn't make a big difference, but I could make a little drop."

So strong was the desire to help his fellow Haitians that Dr. St. Leger sold his house, office building and a thriving practice in East St. Louis and moved to a rural village in Haiti called Petit Paradis, or Little Paradise, about 50 kilometers from the capital city of Port-au-Prince. There, on a half-mile stretch of land he purchased years before "just for vacations," Dr. St. Leger and his wife, Susan, built a home and the St. Pierre Foundation Clinic. "My husband had talked about doing this for the 21 years I'd known him," Mrs. St. Leger said. "He always dreamed of going and helping when he could afford it."

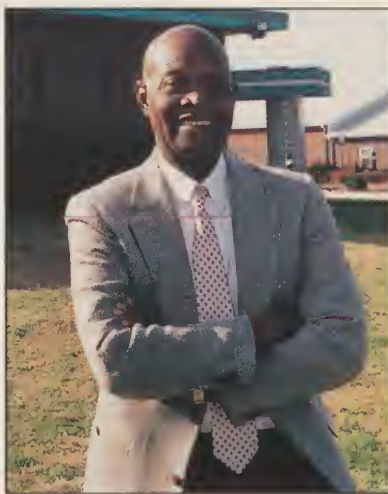
When Dr. St. Leger first moved to Haiti, his wife, a nurse, commuted regularly from a condominium in St. Louis to Petit Paradis and helped organize shipments of medical supplies to the clinic. "I'm kind of a flower child," she said. "I'm not

wrapped up in material things, so when he decided to go, it sounded like an adventure. But I didn't have any intention of living there permanently. It was too

overwhelming, primitive and depressing. We had to stay in a rental while our house was being built. In mango season, rats were fighting on the roof."

They also had to find a way to supply electricity to their home. After they bought electric poles and strung wires to the nearest town, the St. Legers discovered that the city seldom had electricity. They then bought a generator in Miami, Mrs. St. Leger said. "It ran on diesel fuel, which was very expensive. It really was an adventure, and we learned as we went."

Dr. St. Leger and his wife created a foundation to help fund the medical facility he set out to build, but most of the money for maintaining it came from their own pockets. "The foundation was some help but not too much," Dr. St. Leger explained. "As time went on, the [foundation's] help became less and less. So we were financing everything ourselves."



Dr. St. Leger

WHEN THE CLINIC OPENED in the winter of 1990, Dr. St. Leger was the sole physician for the area's 30,000 inhabitants. The clinic had two exam rooms, a pharmacy/lab, a record-keeping area and a three-bed room for patients who needed to stay overnight.

At first, he provided free services, using four duffel bags con-

Photos by Walter Grogan



Now back practicing in the United States, Dr. St. Leger treats patients in an office at Touchette Regional Hospital in Centreville. "I don't know how long I can resist going back," he said.



taining medicine and supplies gathered during frequent trips to the United States and weekly trips to Port-au-Prince. "I was the only physician where I was who had plenty of medicine, so I had quite a few patients. At the beginning, I saw patients for free, even though I'd been advised not to. But the well-to-do started to come and infiltrate. So I started charging 50 cents or \$1 in Haitian money to those who could afford it. But for those who couldn't afford it, it was free. Nobody would leave without treatment."

Ultimately, Dr. St. Leger hired a physician, two nurses, a lab technician and two boys to help with nonmedical office tasks. The staff were all Haitians whose salaries were paid by Dr. St. Leger. "The clinic was growing, and things were getting very hectic. We needed more help."

Medical treatment wasn't the only thing Dr. St. Leger and his associates dispensed at the St. Pierre Foundation Clinic. Many patients also received information about sexually transmitted diseases and family planning, two issues Dr. St. Leger believes are key to curbing Haiti's spiraling population and the related social ills. "The density of the population is such that something has to be done. I would see a little girl with no clothes, a big belly and no hope for her to go to school. Then I saw her mom was going to have another baby. They need birth control. And education is important. Without it, you will not have any change. In any country [in which] people are educated, there is progress. But now in Haiti, I think 70 to 80 percent of the people are not educated, and there will be no progress."

And physical ills weren't the only problems Dr. St. Leger confronted in Haiti. Depression and hopelessness were constant companions for him and the patients he treated. "The hardest part was that I saw such little hope, and that definitely creates depression. There is so much to do. This is a vicious cycle. You will treat someone, but tomorrow he will have no food and bad water. What is tomorrow if tomorrow can't be different than today?"

As political and economic conditions in Haiti declined, Dr. St. Leger found it increasingly difficult to treat those who relied on his services. "I wanted to see the country change, to see progress. I kept thinking it couldn't get worse, but the next year it was worse.

There were daily killings in the streets but no protection from police, who didn't attempt to look for the murderers. Conditions became so hectic and brutal with all the raping and killing that I advised my wife not to come [back]."

During the summer of 1994, commercial air traffic to Haiti was halted, and traveling from the clinic to Port-au-Prince became prohibitively expensive. "The gas for the trip from my spot to Port-au-Prince was \$9 or \$10 a gallon in American money. It was becoming more and more difficult to travel and to get medicine. Patients weren't coming as often because transportation was so expensive. I was missing my wife. And I had a dog and couldn't even find dog food. What I went [to Haiti] for, I couldn't do."

In September, Dr. St. Leger reluctantly decided to join his wife in St. Louis. But leaving the country was difficult, he said. Twice he reached the border but was turned away by officials who rejected the paperwork required to exit Haiti because it carried the signature of only one Haitian general. Finally, a UNICEF physician, who was also a clinic volunteer and served as an ophthalmologist for a Haitian general, obtained the necessary second signature.

Since no cars were available, Dr. St. Leger left Haiti as a passenger on a motorcycle and went to Jimani in the Dominican Republic. "All the time, I had my hand on a knife. I didn't know the motorcycle driver, and I didn't want to be a victim. I was so close to being out."

From Jimani, Dr. St. Leger paid a cab driver \$100 in U.S. currency to take him to Santo Domingo. There, he called his wife and told her he would be home soon.

Today, Dr. St. Leger is practicing internal medicine from an office at Touchette Regional Hospital in Centreville. But he has not put his experience behind him. Instead, he continues sending money and medicine to the clinic he established. "I have to work to continue to finance my clinic," he said, noting that the facility is currently staffed by a Haitian physician and nurse whose salaries he still pays.

Dr. St. Leger said he plans to visit his homeland for a week, later this month. And someday he will probably return to help the poor Haitian villagers. "I don't know how long I can resist going back. I've seen some bright faces, some hope when I treated my patients. That is most rewarding. It is my compensation." ■

Regulatory concerns

(Continued from page 2)

the letter, the department defines HMOs and provides information to help entities gauge whether they are "required to obtain a certificate of authority and comply with statutory and regulatory requirements for HMOs" under the Texas Administrative Code. Each organization is being directed to submit a copy of all contract information, bylaws and fee arrangements to the department's HMO unit.

The department of insurance already requires all Texas insurers and HMOs to provide information about their finan-

cial status, apply for licenses and show proof that they maintain large financial reserves, Rummel said. In addition, the department would issue a cease-and-desist order to any entity engaged in the business of insurance without a certificate of authority and would take regulatory action against organizations that fail to comply, she explained.

In July, the department established a group of health care industry professionals to address health insurance regulation in Texas, Rummel noted. The group was divided into three subcommittees: one to discuss if physician or physician-hospital groups should be able to contract directly with employers, the second

to determine if such entities should be able to contract to provide medical services to HMOs and the third to debate whether insurance companies should be able to capitate.

The subcommittees debating capitation and employer contracting were unable to achieve consensus, Rummel said. But the subcommittee addressing provision of medical services to HMOs by physician or physician-hospital groups is in the process of amending the Texas Administrative Code, she added. "We'll try to amend [the code] to allow one HMO to contract with another HMO, and to allow an HMO to contract with any provider or physician and

allow [the HMO] to pay capitation directly."

THE TEXAS MEDICAL ASSOCIATION shares the department's concerns about the confusion over some PHOs and IPAs, said Hugh Barton, a TMA attorney. "We're concerned that physicians are going to put together these kinds of groups and find themselves under the gun of the insurance department, being required to have \$1 million in reserves [that they don't have]. We're in favor of clarifying whether or not these entities need to be regulated."

Barton would not say whether TMA favors regulation of PHOs and IPAs, but he did say that the issue will require a legislative remedy. "We don't necessarily trust the insurance companies when they say all they want is a level playing field. I don't think this can be done [only] through some sort of policy statement."

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We don't necessarily trust the insurance companies when they say all they want is a level playing field.

Concern over regulation of physician groups is not unique to Texas, said Judee Gallagher, a Chicago attorney in private practice and a participant in ISMS' Lawyer Referral Network. "This issue has bounced around for the past 10 years or so in various states. There are situations in which HMOs are contracting with groups that aren't regulated and shifting the underwriting risk to those groups. Even though there are no requirements for capital reserve, under the contract, they assume the risk. The people who are being regulated are shifting risk to those who aren't."

In Illinois a now-defunct IPA, Quality Care Associates, took on capitated contracts without sufficient reserves in 1990, Gallagher said. The company ended up owing millions of dollars it was unable to pay.

More information about assuming risk in PHOs is included in a study on PHOs conducted by the AMA, ISMS and the Michigan and Indiana medical societies. To order a free copy, ISMS members may call the health care finance division at (312) 782-1654 or (800) 782-ISMS, ext. 1131. ■



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Member direction

(Continued from page 1)

Specifically, the Society is looking for the names of enthusiastic physicians who have shown their expertise and knowledge in a particular area and are willing to work hard and speak out. If you are interested in serving on an ISMS committee or council, please contact your county medical society.

The solicitation process occurs in late March and early April, and the Board of Trustees ratifies appointments at its June meeting. Not all the physicians recommended by county societies can be matched with a council or committee,

and doctors may decline the invitation to serve.

One doctor who has served for three years on the Council on Medical Services is Michael Murphy, MD, a Belleville neurosurgeon. Dr. Murphy said he has been active in organized medicine since 1975, beginning at the county level and then moving up to ISMS. He has served on "one committee or another for the last 20 years" and is a former member of the ISMS House of Delegates. In addition to serving on the Council on Medical Services, Dr. Murphy sits on the Physician Review and Evaluation Panel for ISMIE.

All physicians should become involved in organized medicine in some capacity, Dr. Murphy said. "I think it's every physician's civic duty to participate at a level other than local. If you don't participate, you'll never be heard."

As a member of the Council on Medical Services, Dr. Murphy has dealt with issues ranging from OSHA regulations and the Clinical Laboratory Improvement Amendments to medical waste, emergency medical services and environmental and community health. Recently, the council considered resolutions adopted by the ISMS House of Delegates on such topics as tuberculosis and violence and forwarded recommendations for action to the Governmental Affairs Council.

"Being on a council or committee helps keep you abreast of organized medicine's current thinking," Dr. Murphy concluded. "It helps you understand how organized medicine is in there pitching for the people in the trenches." ■



Dawn Clark Netsch

Who does what?

ISMS physician members may be appointed to any of more than 20 councils and committees, each with specific responsibilities and purposes.

The following are the Society's councils:

- Council on Economics
- Council on Education and Manpower
- Governmental Affairs Council
- Medical Legal Council
- Council on Medical Services
- Council on Mental Health and Addiction
- Council on Public Relations and Membership Services

The following are ISMS' committees:

- Advisory Committee to the Alliance*
- Audit Committee*
- Committee on CME Accreditation
- CME Accreditation Appeals Panel
- Committee on CME Activities
- Committee on Constitution and Bylaws*
- Committee on Drugs and Therapeutics
- Executive Committee*
- Finance and Medical Benevolence Committee*
- Committee on Financial Aid to Medical Students
- Committee on Health Care Access
- Committee on Health System Reform*
- Illinois Medicine Committee*
- Peer Review Appeals Committee
- Physician Assistance Committee
- Policy Committee*
- Standing Committee of the House of Delegates, Judicial Panel (elected by the House of Delegates)
- Third Party Payment Processes Committee*

*Committees of the Board of Trustees

Future issues of Illinois Medicine will highlight each council and committee.

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Medicaid

(Continued from page 1)

midpoint of the approval process and in the process of clarifying details. It's a normal part of the process."

Some of the concerns raised by HCFA echo those ISMS has expressed. For example, ISMS had advocated a more realistic time frame for the program's implementation and questioned whether IDPA's proposal allowed for adequate patient education, continuity of care and patient choice. "The HCFA action means that IDPA will now have more time to implement the Medicaid reform program. So the process can be more deliberate and allow trouble-shooting of potential problems," said ISMS President Alan M. Roman, MD. "On the other hand, there are budget implications that will result from the delay. ISMS will continue providing input to IDPA to ensure that the concerns of patients and physicians are heard."

UNDER IDPA'S original proposal, Medicaid recipients would have had only 20 days to choose a primary care provider before being "defaulted" to a capitated HMO or managed care community network. Medicaid reform would create these MCCNs, which would be HMO look-alikes and would serve Medicaid patients exclusively. Such entities must be governed and controlled by providers, according to an ISMS spokesperson. IDPA had asked HCFA to approve waivers allowing MCCNs to treat only Medicaid patients and permitting the

department to assign a primary care provider to Medicaid recipients who don't select one and to lock them into that provider for one year. Current federal law prohibits state Medicaid programs from locking recipients into capitated systems for more than six months and from allowing more than 75 percent

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Medicaid reform
program.*

of a capitated entity's total enrollment to be composed of Medicaid patients, the ISMS spokesperson explained.

But HCFA doesn't favor use of 1115 waivers allowing states a broad bypass of certain Medicaid managed care provisions unless the proposal includes expanded coverage to uninsured individuals. Illinois' proposal does not expand coverage. "In the absence of an expansion, we believe Illinois should consider pursuing program waivers under [a different section of the code]," HCFA said.

Filing for the required waivers under a different section of the federal code could further complicate implementation, the Society spokesperson said. The

waiver type HCFA wants the state to pursue is restrictive and "isn't usually used to waive the rule that Medicaid clients may compose no more than 75 percent of a capitated entity's enrollees."

HCFA also questioned the program's pediatric and mental health carve-out provisions and their impact on required budget neutrality. "In light of the number of carve-out services that are proposed and the complexities that will be involved in tracking the expenses of each service, it will be difficult to establish budget-neutrality caps for covered managed care services," the letter said. "To achieve the critically important goal of budget neutrality, the state should give consideration to including more of the carve-out services into the basic package or including carve-out services in the budget cap."

In addition, HCFA questioned the state's proposed reliance on mass mailings to educate recipients about changes in the Medicaid plan and their opportunity to select a primary care provider. IDPA has indicated that some 70 percent of enrollees could be defaulted into managed care plans. "We believe that a 70-percent default assignment rate would be a failure in the education process," HCFA noted. "The state must develop an enrollment process that will result in a large percentage of beneficiaries choosing their own plans."

The absence of an adequate transition plan and the lack of information about a new management information system for Medicaid are also under federal scrutiny, according to the letter. Specifically, HCFA said IDPA needs a "good transi-

tion plan to ensure that people and systems are in place to guarantee continuity of care for individuals with special needs or who currently have established relationships with a provider of care." IDPA must also specify how the state will monitor services to identify an absence of care and duplication of services.

IDPA had estimated that MediPlan Plus would save \$173 million per year and that the savings would increase over time. "The important thing to realize is that the waiver is a 5-year demonstration project. So no matter when it takes effect, we'll still realize a 5-year savings estimated at \$2 billion," Schott said. "The savings won't be lost, just delayed." ■



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Women's health

(Continued from page 1)

Mary Mulligan (R-Des Plaines), and state Sens. Karen Hasara (R-Springfield) and Alice Palmer (D-Chicago).

Although attendees agreed on the need for increased access for women, views differed about how to provide it. Focusing on reproductive rights, Gail Riedmann, chairman of the Illinois Birth Center Task Force, said she hopes the Illinois Alternative Health Care Act will be amended to allow a pilot program of freestanding birth centers. Riedmann said that locating centers around Illinois would provide quality reproductive care while lowering costs and improving access in underserved areas.

The safety of freestanding birth centers was questioned, however, by Maqbool Ali, MD, a Peoria Ob/Gyn. In fact, Dr. Ali said she believes such centers would reduce the quality of care for underserved populations. "A woman in labor is like a ticking bomb. Most problems come with no previous warning, and many patients need immediate attention, including general anesthetic and life-support equipment. At a birthing center, when you have to contact a new physician and transport a patient in the middle of a crisis, you may lose the baby or reduce its quality of life."

Another means of boosting access would be legislation allowing for direct reimbursement of nurse practitioners, according to Amy Coen, executive director of Planned Parenthood of Chicago. But Dr. Ali said she does not view direct reimbursement of nurse practitioners as the best way to address access issues. She said there are enough physicians available in Illinois to achieve universal access. "If physicians were reimbursed more quickly for their services, they might be more willing to work in underserved areas." She stressed that only physicians have the medical training essential to the safety of mother and child during labor and delivery.

Inadequate funding for Medicaid services has created access barriers for many women and children on public aid, said Janis Orlowski, MD, a nephrologist at Rush-Presbyterian-St. Luke's Medical Center in Chicago and an ISMS Third District trustee. To serve those patients uniformly, the state must solve the problems of low and slow Medicaid reimbursement, she said. In addition, the state could improve health care coverage by passing a cap on noneconomic damages in medical malpractice suits, reforming the insurance industry, returning the control of health care dollars to patients and creating government and private sector partnerships, she added. "Physicians in Illinois are dedicated to bringing quality medical care to all people in Illinois."

OTHER SPEAKERS addressed topics related to mental health, drug abuse and aging. Patricia Sanderson, chairman of the Illinois chapter of the American Cancer Society, told the legislators that the state needs a compliance testing law to curtail the sale of tobacco products to minors. Sanderson added that the state should support access to mammography for women between the ages of 40 and 49. "Half of the 46,000 women who die each year of breast cancer could be saved by early detection and treatment."

The devastating and costly consequences of untreated depression and

substance abuse were discussed by Claudia Joyner, MD, a psychiatrist at Northwestern Memorial Hospital in Chicago. Access could be improved by removing barriers such as the lack of insurance coverage and dispelling stereotypes that suggest depression is a character weakness, Dr. Joyner said. Increasing the number of treatment facilities to handle depression and substance abuse would also help, she noted.

Teresa Savino, a family nurse practitioner at Chicago Health Outreach, specifically advocated direct reimbursement for nurse practitioners working in the mental health field. In response, Dr. Joyner said: "As a psychiatrist, I respect

the people I work with, including nurse practitioners. But I'm trained to diagnose and treat mental illness, and in the matter of Medicaid reimbursement, that's where the emphasis should be."

More government support for long-term caregivers is also necessary, said Ruth Christmas, a private citizen who spent several years unemployed while she cared for her aging mother. Dr. Cum-

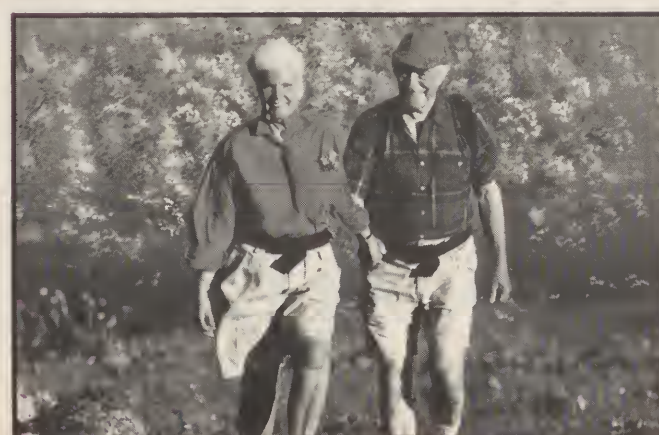


Dr. Joyner

Ron Ackerman

ings noted that long-term and chronic care did not receive much attention during the federal health care reform debate. "For older adults who need some assistance with the activities of daily living, we need to coordinate services among agencies and plan collaborative, not competitive, community care."

In addition to the legislators hosting the hearing, several lawmakers sat in on the program. Copies of the testimony presented will be distributed to all members of the General Assembly. "I thought it was an excellent program," Krause said. "I'm looking forward to its leading to something constructive we can work on in the new assembly." ■



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